




The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE:** Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go to <https://www.eugene-or.gov/employeebenefits> or call 541-682-5061. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [co-insurance](#), [co-payment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary> or call 541-682-5061 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	\$150/individual or \$450/family	Generally, you must pay all the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. Doesn't apply to pharmacy, <a href="#">preventive care</a> , some services due to accidental injury, outpatient surgery physician/facility charges, and routine exams/hardware under vision plan.	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">co-payment</a> or <a href="#">co-insurance</a> may apply.
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	Yes. Dental care other than <a href="#">preventive care</a> : \$50/individual or \$150/family. There are no other specific <a href="#">deductibles</a> .	You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	\$1,000/individual medical \$1,000/individual pharmacy	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	<a href="#">Premiums</a> , <a href="#">deductibles</a> , <a href="#">balance-billing</a> charges, dental benefits and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes. See <a href="http://www.PacificSource.com">www.PacificSource.com</a> or call 1-888-532-5332 for medical/vision/pharmacy, or see <a href="http://www.modahealth.com">www.modahealth.com</a> or call 1-888-217-2365 for dental, for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance-billing</a> ). Be aware your <a href="#">in-network provider</a> may use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 All [co-payment](#) and [co-insurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information*
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness  Teladoc telehealth consults	PCP: 20% <a href="#">co-insurance</a> <a href="#">Deductible</a> does not apply: for accidental injury. Teladoc: No charge. <a href="#">Deductible</a> does not apply.	50% <a href="#">co-insurance</a> <a href="#">Deductible</a> does not apply for treatment of accidental injury	Teladoc consults: No charge only if Teladoc account activated through PacificSource. Standard co-insurance and/or <a href="#">deductible</a> apply for other telemedicine services.
	<a href="#">Specialist</a> visit	20% <a href="#">co-insurance</a> <a href="#">Deductible</a> does not apply for treatment of accidental injury	50% <a href="#">co-insurance</a> <a href="#">Deductible</a> does not apply for treatment of accidental injury	None
	Other practitioner office visit Acupuncture Chiropractic Care Massage Therapy Registered Dietician Naturopath	20% <a href="#">co-insurance</a> 20% <a href="#">co-insurance</a> 20% <a href="#">co-insurance</a> 20% <a href="#">co-insurance</a> 20% <a href="#">co-insurance</a>	20% <a href="#">co-insurance</a> 20% <a href="#">co-insurance</a> 20% <a href="#">co-insurance</a> 20% <a href="#">co-insurance</a> 20% <a href="#">co-insurance</a>	None Chiropractic 52 visits/cal yr limit Massage Therapy \$300/cal yr limit Dietician \$200/cal yr limit. Naturopath \$300/cal yr limit. No coverage for naturopathic and homeopathic remedies and prescriptions.
	<a href="#">Preventive care/screening</a> /Immunization Routine Physicals Well Baby/Child Visit Newborn nurse home visit Routine Gynecological Exam Tobacco Cessation Immunizations Preventive Colonoscopy COVID-19 vaccine, testing, and related services	20% <a href="#">co-insurance</a> 20% <a href="#">co-insurance</a> No charge 20% <a href="#">co-insurance</a> No charge 20% <a href="#">co-insurance</a> 20% <a href="#">co-insurance</a> No charge  <a href="#">Deductible</a> does not apply	50% <a href="#">co-insurance</a> 50% <a href="#">co-insurance</a> 50% <a href="#">co-insurance</a> 50% <a href="#">co-insurance</a> No charge No charge 50% <a href="#">co-insurance</a> 50% <a href="#">co-insurance</a> No charge  <a href="#">Deductible</a> does not apply	Limited to: Routine Physicals/Well Baby: no visit limit through age 12 months, age 13-36 months covered per Health Resources & Services Administration preventative care schedule, annually age 3+ yrs. Newborn nurse home visits: up to age 6 months. Tobacco Cessation: age 15+ yrs. Routine Gynecological Exam: annually. Immunizations: CDC and USPSTF Preventive Care Grade A and B Recommended. You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are preventive. Then check what your <a href="#">plan</a> will pay for.

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.eugene-or.gov/EmployeeBenefits](http://www.eugene-or.gov/EmployeeBenefits)

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information*
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% <a href="#">co-insurance</a> <a href="#">Deductible</a> does not apply for treatment of accidental injury	50% <a href="#">co-insurance</a> <a href="#">Deductible</a> does not apply for treatment of accidental injury	None
	Imaging (CT/PET scans, MRIs)	20% <a href="#">co-insurance</a> <a href="#">Deductible</a> does not apply for treatment of accidental injury	50% <a href="#">co-insurance</a> <a href="#">Deductible</a> does not apply for treatment of accidental injury	None
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="https://www.pacificsource.com/drug-list/">https://www.pacificsource.com/drug-list/</a>	Tier 1 (mostly Generic drugs)	Retail or Mail-order: \$10 <a href="#">co-pay</a> /prescription or 10% <a href="#">co-insurance</a> , whichever is greater <a href="#">Deductible</a> does not apply	Retail: \$10 <a href="#">co-pay</a> /prescription or 10% <a href="#">co-insurance</a> , whichever is greater <a href="#">Deductible</a> does not apply	Retail day supply unlimited. Mail limited to 90-day supply. <a href="#">Preauthorization</a> required for certain drugs. Retail and mail order subject to medical out-of-pocket limit of \$1,000/year. Once out-of-pocket limit reached, <a href="#">co-pays</a> for drugs obtained from a participating pharmacy are waived for the remainder of year. Differential between generic and brand drugs, and non-participating retail pharmacy charges do not apply to the out-of-pocket limit.
	Tier 2 (Preferred brand drugs, some Generic drugs)	Retail or Mail-order: \$15 <a href="#">co-pay</a> /prescription or 20% <a href="#">co-insurance</a> , whichever is greater <a href="#">Deductible</a> does not apply	Retail: \$15 <a href="#">co-pay</a> /prescription or 20% <a href="#">co-insurance</a> , whichever is greater <a href="#">Deductible</a> does not apply	
	Tier 3 (Non-preferred brand drugs)	Retail or Mail-order: \$25 <a href="#">co-pay</a> /prescription or 25% <a href="#">co-insurance</a> , whichever is greater <a href="#">Deductible</a> does not apply	Retail: \$25 <a href="#">co-pay</a> /prescription or 25% <a href="#">co-insurance</a> , whichever is greater <a href="#">Deductible</a> does not apply	
	<a href="#">Specialty drugs</a>	Retail or Mail-order: \$25 <a href="#">co-pay</a> /prescription or 25% <a href="#">co-insurance</a> , whichever is greater <a href="#">Deductible</a> does not apply	Retail: \$25 <a href="#">co-pay</a> /prescription or 25% <a href="#">co-insurance</a> , whichever is greater <a href="#">Deductible</a> does not apply	

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.eugene-or.gov/EmployeeBenefits](http://www.eugene-or.gov/EmployeeBenefits)

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information*
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">co-insurance</a>	50% <a href="#">co-insurance</a>	None
	Physician/surgeon fees	No charge <a href="#">Deductible</a> does not apply	50% <a href="#">co-insurance</a> <a href="#">Deductible</a> does not apply	None
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	20% <a href="#">co-insurance</a> <a href="#">Deductible</a> does not apply for treatment of accidental injury.	20% <a href="#">co-insurance</a> <a href="#">Deductible</a> does not apply for treatment of accidental injury.	Non-participating paid as participating if emergency medical condition.
	<a href="#">Emergency medical transportation</a> Ground Ambulance Air Ambulance	20% <a href="#">co-insurance</a>	20% <a href="#">co-insurance</a>	Limited to nearest facility able to treat condition. Air covered if ground medically or physically inappropriate. <a href="#">Preauthorization</a> may be required.
	<a href="#">Urgent care</a>	20% <a href="#">co-insurance</a> <a href="#">Deductible</a> does not apply for treatment of accidental injury.	50% <a href="#">co-insurance</a> <a href="#">Deductible</a> does not apply for treatment of accidental injury.	None
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	20% <a href="#">co-insurance</a>	50% <a href="#">co-insurance</a>	Limited to semi-private room unless intensive or coronary care units, medically necessary isolation, or hospital only has private rooms. <a href="#">Preauthorization</a> required for inpatient elective surgery.
	Physician/surgeon fees	20% <a href="#">co-insurance</a>	50% <a href="#">co-insurance</a>	None
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	20% <a href="#">co-insurance</a>	20% <a href="#">co-insurance</a>	None
	Inpatient services	20% <a href="#">co-insurance</a>	20% <a href="#">co-insurance</a>	<a href="#">Preauthorization</a> required.
<b>If you are pregnant</b>	Office visits	20% <a href="#">co-insurance</a>	50% <a href="#">co-insurance</a>	Depending on the type of services, a <a href="#">co-payment</a> or <a href="#">deductible</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	20% <a href="#">co-insurance</a>	50% <a href="#">co-insurance</a>	
	Childbirth/delivery facility services Free Standing Birthing Centers	20% <a href="#">co-insurance</a> No charge	50% <a href="#">co-insurance</a> 50% <a href="#">co-insurance</a>	

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.eugene-or.gov/EmployeeBenefits](http://www.eugene-or.gov/EmployeeBenefits)

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information*
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	No charge	20% <a href="#">co-insurance</a>	Limited to 100 four-hour visits/calendar year. <a href="#">Preauthorization</a> required. No coverage for private duty nursing.
	<a href="#">Rehabilitation services</a> Inpatient Outpatient	20% <a href="#">co-insurance</a> 20% <a href="#">co-insurance</a>	50% <a href="#">co-insurance</a> 20% <a href="#">co-insurance</a>	<a href="#">Preauthorization</a> may be required for inpatient services. Limited to 30 visits combined per calendar year for most services. Includes physical therapy, speech therapy, occupational therapy, and pulmonary rehabilitation combined. Covered for restoring certain functional losses due to disease, illness, or injury only. No coverage for recreational therapy or maintenance services.
	<a href="#">Habilitation services</a> Inpatient Outpatient	20% <a href="#">co-insurance</a> 20% <a href="#">co-insurance</a>	50% <a href="#">co-insurance</a> 20% <a href="#">co-insurance</a>	
	<a href="#">Skilled nursing care</a>	50% <a href="#">co-insurance</a>	50% <a href="#">co-insurance</a>	Limited to 60 days/calendar year. <a href="#">Preauthorization</a> required. No coverage for custodial care.
	<a href="#">Durable medical equipment</a>	20% <a href="#">co-insurance</a>	20% <a href="#">co-insurance</a>	Must be prescribed by physician; rental covered up to rental equipment purchase price when prescribed by physician; hearing aid for children limited to one per hearing impaired ear per 36 months, hearing aids for adults limited to \$500 per 36 months and requires 50% co-insurance for participating and non-participating providers. <a href="#">Preauthorization</a> required over \$800.
	<a href="#">Hospice services</a>	No charge	No charge	No coverage for private duty nursing.

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.eugene-or.gov/EmployeeBenefits](http://www.eugene-or.gov/EmployeeBenefits)

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information*
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	20% <a href="#">co-insurance</a> <a href="#">Deductible</a> does not apply	20% <a href="#">co-insurance</a> <a href="#">Deductible</a> does not apply	Limited to one exam per 12 months.
	Children's glasses	No charge <a href="#">Deductible</a> does not apply	No charge <a href="#">Deductible</a> does not apply	For children under age 19. Prescription frames and lenses OR contacts (once every 12 months). Contacts limited to the following per year: Standard (one pair annually): 1 contact lens per eye (2 lenses total); Monthly (six month supply) or Biweekly (3 month supply): 6 lenses per eye (12 lenses total); Dailies (one month supply): 30 lenses per eye (60 lenses total).
	Children's dental check-up	No charge <a href="#">Deductible</a> does not apply	No charge <a href="#">Deductible</a> does not apply	Preventive examinations every 6 months. Age 19 and over, benefit is limited to \$1,500 per person each calendar year.

#### Excluded Services & Other Covered Services:

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>• Cosmetic surgery</li> <li>• Custodial care</li> <li>• Infertility treatment</li> </ul>	<ul style="list-style-type: none"> <li>• Long term care</li> <li>• Outpatient recreational therapy</li> </ul>	<ul style="list-style-type: none"> <li>• Private duty nursing</li> <li>• Routine foot care, other than with diabetes mellitus</li> </ul>
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)		
<ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Bariatric surgery</li> <li>• Chiropractic care (limited to 52 visits/year)</li> </ul>	<ul style="list-style-type: none"> <li>• Dental care (Adult)</li> <li>• Hearing aids (limited to \$500 per 36 months)</li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>• Routine eye care (Adult)</li> <li>• Weight loss programs</li> </ul>

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: PacificSource at 1-888-977-9299, State of Oregon insurance department at 1-800-318-2596 (toll-free) (TTY: 855-889-4325) or [healthcare.oregon.gov](http://healthcare.oregon.gov), the U.S. Department of Labor [www.dol.gov](http://www.dol.gov), Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform), or the U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).

Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: PacificSource Customer Service Department at 1-888-977-9299. Additionally, a consumer assistance program can help you file your [appeal](#). Contact the Oregon Insurance Division's Consumer Advocacy Unit at 1-503-947-7984 or toll-free at 1-888-877-4894.

**Does this plan provide Minimum Essential Coverage? Yes**

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

**Does this plan meet the Minimum Value Standards? Yes**

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

**Language Access Services:**

[Spanish (Español): Para obtener asistencia en Español, llame al 1-888-977-9299]

*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*

**PRA Disclosure Statement:** According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [co-payments](#) and [co-insurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

**Peg is Having a Baby**  
(9 months of in-network pre-natal care and a hospital delivery)

- The [plan's](#) overall [deductible](#) \$150
- [Specialist coinsurance](#) 20%
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

This EXAMPLE event includes services like:

- [Specialist](#) office visits (*prenatal care*)
- Childbirth/Delivery Professional Services
- Childbirth/Delivery Facility Services
- [Diagnostic tests](#) (*ultrasounds and blood work*)
- [Specialist](#) visit (*anesthesia*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$150
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$1,020
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$1,230</b>

**Managing Joe's type 2 Diabetes**  
(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$150
- [Specialist coinsurance](#) 20%
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

This EXAMPLE event includes services like:

- [Primary care physician](#) office visits (*including disease education*)
- [Diagnostic tests](#) (*blood work*)
- [Prescription drugs](#)
- [Durable medical equipment](#) (*glucose meter*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$150
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$1,225
What isn't covered	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,395</b>

**Mia's Simple Fracture**  
(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$150
- [Specialist coinsurance](#) 20%
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

This EXAMPLE event includes services like:

- [Emergency room care](#) (*including medical supplies*)
- [Diagnostic test](#) (*x-ray*)
- [Durable medical equipment](#) (*crutches*)
- [Rehabilitation services](#) (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$150
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$540
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$690</b>