
 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:
What is the overall deductible ?	\$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible ?	No	You will have to meet the deductible before the plan pays for any services.
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan ?	Not Applicable.	This plan does not have an out-of-pocket limit on your expenses.
What is not included in the out-of-pocket limit ?	Not Applicable	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Will you pay less if you use a network provider ?	Not Applicable	This plan does not use a provider network . You can receive covered services from any provider .
Do you need a referral to see a specialist ?	No	You can see the specialist you choose without a referral .

 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)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Not Covered	Not Covered	None
	Specialist visit	Not Covered	Not Covered	None
	Preventive care/screening /immunization	Not Covered	Not Covered	None
If you have a test	Diagnostic test (x-ray, blood work)	Not Covered	Not Covered	None
	Imaging (CT/PET scans, MRIs)	Not Covered	Not Covered	None

If you need drugs to treat your illness or condition. More information about prescription drug coverage is available at https://www.pacificsource.com/drug-list/	Generic drugs	Not Covered	Not Covered	None
	Preferred brand drugs	Not Covered	Not Covered	
	Non-preferred brand drugs	Not Covered	Not Covered	
	Specialty drugs	Not Covered	Not Covered	None
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not Covered	Not Covered	None
	Physician/surgeon fees	Not Covered	Not Covered	None
If you need immediate medical attention	Emergency room care	Not Covered	Not Covered	None
	Emergency medical transportation	Not Covered	Not Covered	None
	Urgent care	Not Covered	Not Covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	Not Covered	Not Covered	None
	Physician/surgeon fees	Not Covered	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	Not Covered	Up to 4 EAP counseling sessions per problem per year per provider covered under EAP services. Cascade Behavioral Health and EAP no shows/late cancellations count as one visit. MTR Therapy no shows/late cancellations subject to \$30 fee as member responsibility and are not covered under the plan .
	Inpatient services	Not Covered	Not Covered	None
If you are pregnant	Office visits	Not Covered	Not Covered	None
	Childbirth/delivery professional services	Not Covered	Not Covered	
	Childbirth/delivery facility services	Not Covered	Not Covered	
If you need help recovering or have other special health needs	Home health care	Not Covered	Not Covered	None
	Rehabilitation services	Not Covered	Not Covered	
	Habilitation services	Not Covered	Not Covered	None
	Skilled nursing care	Not Covered	Not Covered	
	Durable medical equipment	Not Covered	Not Covered	
	Hospice services	Not Covered	Not Covered	
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	None
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

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

Excluded Services & Other Covered Services:

Services Your [Plan](#) Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other [excluded services](#).)

- | | | |
|--------------------------------------|--|--|
| • Acupuncture | • Hearing aids | • Private duty nursing |
| • Bariatric surgery | • Infertility treatment Long term care | • Routine eye care (Adult) |
| • Chiropractic care Cosmetic surgery | • Non-emergency care when traveling outside the U.S. | • Routine foot care, other than with diabetes mellitus |
| • Custodial care | • Outpatient recreational therapy | • Weight loss programs |
| • Dental care (Adult) | | |

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

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, the U.S. Department of Labor www.dol.gov, Employee Benefits Security Administration at 1-866-444-3272 or 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.

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 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? **Not Applicable**

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 541-682-5791

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

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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](#) N/A
- [Specialist](#) [cost sharing] N/A
- Hospital (facility) [cost sharing] N/A
- Other [cost sharing] N/A

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)

Total Example Cost	\$12,700
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In this example, Peg would pay: This condition is not covered, so patient pays 100%

Cost Sharing	
Deductibles	N/A
Copayments	N/A
Coinsurance	N/A
What isn't covered	
Limits or exclusions	N/A
The total Peg would pay is	\$12,700

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

- The [plan's](#) overall [deductible](#) N/A
- [Specialist](#) [cost sharing] N/A
- Hospital (facility) [cost sharing] N/A
- Other [cost sharing] N/A

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)

Total Example Cost	\$5,600
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In this example, Joe would pay: This condition is not covered, so patient pays 100%

Cost Sharing	
Deductibles	N/A
Copayments	N/A
Coinsurance	N/A
What isn't covered	
Limits or exclusions	N/A
The total Joe would pay is	\$5,600

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

- The [plan's](#) overall [deductible](#) N/A
- [Specialist](#) [cost sharing] N/A
- Hospital (facility) [cost sharing] N/A
- Other [cost sharing] N/A

This EXAMPLE event includes services like:

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

Total Example Cost	\$2,800
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In this example, Mia would pay: This condition is not covered, so patient pays 100%

Cost Sharing	
Deductibles	N/A
Copayments	N/A
Coinsurance	N/A
What isn't covered	
Limits or exclusions	N/A
The total Mia would pay is	\$2,800