
 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 <http://www.eugene-or.gov/employeebenefits> or by calling 541-682-5062. 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 541-682-5062 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$0	See the Common Medical Events chart below for your costs for services this <a href="#">plan</a> covers.
Are there services covered before you meet your <a href="#">deductible</a> ?	No	You will have to meet the <a href="#">deductible</a> before the plan pays for any services.
Are there other <a href="#">deductibles</a> for specific services?	No	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	Not Applicable.	This <a href="#">plan</a> does not have an <a href="#">out-of-pocket limit</a> on your expenses.
What is not included in the <a href="#">out-of-pocket limit</a> ?	Not Applicable	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Not Applicable	This <a href="#">plan</a> does not use a <a href="#">provider network</a> . You can receive covered services from any <a href="#">provider</a> .
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	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	Not Covered	Not Covered	None
	<a href="#">Specialist</a> visit	Not Covered	Not Covered	None
	Other practitioner office visit Acupuncture Chiropractic Care Massage Therapy Naturopath	Not Covered	Not Covered	None
	<a href="#">Preventive care/screening</a> /immunization Routine Physicals Well Baby/Child Visit Routine Gynecological Exam Tobacco Cessation Immunizations Preventive Colonoscopy	Not Covered	Not Covered	None
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	Not Covered	Not Covered	None
	Imaging (CT/PET scans, MRIs)	Not Covered	Not Covered	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	Generic drugs	Not Covered	Not Covered	None
	Preferred brand drugs	Not Covered	Not Covered	
	Non-preferred brand drugs	Not Covered	Not Covered	

\* For more information about limitations and exceptions, see the plan or policy document at <https://www.eugene-or.gov/253/Employee-Benefits>

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)	
<a href="https://www.pacificsource.com/drug-list/">https://www.pacificsource.com/drug-list/</a>	<a href="#">Specialty drugs</a>	Not Covered	Not Covered	None
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	Not Covered	Not Covered	None
	Physician/surgeon fees	Not Covered	Not Covered	None
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	Not Covered	Not Covered	None
	<a href="#">Emergency medical transportation</a> Ground Ambulance Air Ambulance	Not Covered	Not Covered	None
	<a href="#">Urgent care</a>	Not Covered	Not Covered	None
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	Not Covered	Not Covered	None
	Physician/surgeon fees	Not Covered	Not Covered	None
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	Not Covered	Not Covered	Up to 4 counseling sessions per problem per year covered at no cost under EAP services. MTR Therapy no shows/late cancellations subject to \$30 fee as member responsibility.
	Inpatient services	Not Covered	Not Covered	None
<b>If you are pregnant</b>	Office visits	Not Covered	Not Covered	None
	Childbirth/delivery professional services	Not Covered	Not Covered	

\* For more information about limitations and exceptions, see the plan or policy document at <https://www.eugene-or.gov/253/Employee-Benefits>

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)	
	Childbirth/delivery facility services Free Standing Birthing Centers	Not Covered	Not Covered	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	Not Covered	Not Covered	None
	<a href="#">Rehabilitation services</a> Inpatient Outpatient	Not Covered	Not Covered	None
	<a href="#">Habilitation services</a> Inpatient Outpatient	Not Covered	Not Covered	
	<a href="#">Skilled nursing care</a>	Not Covered	Not Covered	None
	<a href="#">Durable medical equipment</a>	Not Covered	Not Covered	None
	<a href="#">Hospice services</a>	Not Covered	Not Covered	None
	<b>If your child needs dental or eye care</b>	Children's eye exam	Not Covered	Not Covered
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 <https://www.eugene-or.gov/253/Employee-Benefits>

## 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](#).)

- Cosmetic surgery
- Custodial care
- Infertility treatment
- Long term care
- Non-emergency care when traveling outside the U.S.
- Outpatient recreational therapy
- Private duty nursing
- Routine foot care, other than with diabetes mellitus

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

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Dental care (Adult)
- Hearing aids
- Routine eye care (Adult)
- Weight loss programs

**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**

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

### 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.*—————

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](#) [*cost sharing*] 20%
- Hospital (facility) [*cost sharing*] 20%
- Other [*cost sharing*] 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:**

<i>Cost Sharing</i>	
Deductibles	\$150
Co-payments	\$0
Co-insurance	\$850
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$1,000</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](#) [*cost sharing*] 20%
- Hospital (facility) [*cost sharing*] 20%
- Other [*cost sharing*] 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>\$7,400</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
Deductibles	\$150
Co-payments	\$0
Co-insurance	\$850
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$1,000</b>

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

- The [plan's](#) overall [deductible](#) \$150
- [Specialist](#) [*cost sharing*] 20%
- Hospital (facility) [*cost sharing*] 20%
- Other [*cost sharing*] 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>\$1,900</b>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
Deductibles	\$150
Co-payments	\$0
Co-insurance	\$350
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$500</b>