**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://PacificSource.com/studenthealth/. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary HealthCare.gov/sbc-glossary or call 1-888-977-9299 to request a copy.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | Tier One and Tier Two In-network provider: $500 individual \| Out-of-network provider: $1,000 individual | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. |
| **Are there services covered before you meet your deductible?** | Yes. Tier One In-network provider services and Tier Two In-network provider preventive care; office visits; durable medical equipment. Rx drugs. Vision age 18 and younger - Vision exam and hardware. | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at Healthcare.gov/coverage/preventive-care-benefits/. |
| **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** | Tier One and Tier Two In-network provider: $4,000 individual \| Out-of-network provider: $8,000 individual | The out-of-pocket limit is the most you could pay in a year for covered services. |
| **What is not included in the out-of-pocket limit?** | Premiums, balance-billing charges, and health care this plan doesn't cover. | 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?** | Yes. See Providerdirectory.pacificsource.com/?nPlan=Navigator or call 1-888-977-9299 for a list of network providers. | This plan uses a provider network. You pay the least if you use a provider in the Student Health Center. You pay more if you use an in-network provider. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| **Do you need a referral to see a specialist?** | No. | You can see the specialist you choose without a referral. |

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

| What You Will Pay | | | | | |
|---|---|---|---|---|---|
| **Common Medical Event** | **Services You May Need** | **Health & Counseling Center: (You will pay the least)** | **In-network (You will pay more)** | **Out-of-network (You will pay the most)** | **Limitations, Exceptions, & Other Important Information** |
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | No charge, deductible does not apply | 20% co-insurance | 40% co-insurance | None |
| | Specialist visit | Not available | 20% co-insurance | 40% co-insurance | None |
| | Preventive care/screening/immunization | No charge, deductible does not apply | No charge, deductible does not apply | 40% co-insurance | Preventive Physicals: 13 visits ages 0-36 months, annually ages 3 and older. Well Woman Visits: annually. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. Tobacco cessation: Not covered out-of-network. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | Not available | 20% co-insurance | 40% co-insurance | None |
| | Imaging (CT/PET scans, MRIs) | Not available | 20% co-insurance | 40% co-insurance | Preauthorization required. |
| | Tier one drugs | Retail: Not available<br>Mail: Not available | Retail: $20 co-pay, deductible does not apply<br>Mail: $50 co-pay, deductible does not apply | 90% co-insurance, deductible does not apply | |

| What You Will Pay | | | | | |
|---|---|---|---|---|---|
| **Common Medical Event** | **Services You May Need** | **Health & Counseling Center: (You will pay the least)** | **In-network (You will pay more)** | **Out-of-network (You will pay the most)** | **Limitations, Exceptions, & Other Important Information** |
| **If you need drugs to treat your illness or condition** More information about prescription drug coverage is available at https://pacificsource.com/drug-list | Tier two drugs | Retail: Not available<br>Mail: Not available | Retail: $40 co-pay, deductible does not apply<br>Mail: $100 co-pay, deductible does not apply | 90% co-insurance, deductible does not apply | Prescription benefit includes certain outpatient drugs as a preventive benefit at no charge when received in-network, deductible does not apply. Cost share amounts shown represent a 30 day supply at retail and a 90 day supply at mail order. Quantity for retail is limited to 30 day supply. Quantity for mail order is limited to 90 day supply. Quantity for Specialty drug is limited to 30 day supply.<br>Preauthorization required for certain drugs. If a manufacturer coupon or rebate is used, the amount of the discount will not accumulate toward the deductible or the maximum out-of-pocket limit. |
| | Tier three drugs | Retail: Not available<br>Mail: Not available | Retail: $60 co-pay, deductible does not apply<br>Mail: $150 co-pay, deductible does not apply | 90% co-insurance, deductible does not apply | |
| | Tier four drugs | Not available | Retail: $60 co-pay, deductible does not apply<br>Mail: $150 co-pay, deductible does not apply | 90% co-insurance, deductible does not apply | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | Not available | 20% co-insurance | 40% co-insurance | None |
| | Physician/surgeon fees | Not available | 20% co-insurance | 40% co-insurance | |

| What You Will Pay | | | | | |
|---|---|---|---|---|---|
| **Common Medical Event** | **Services You May Need** | **Health & Counseling Center: (You will pay the least)** | **In-network (You will pay more)** | **Out-of-network (You will pay the most)** | **Limitations, Exceptions, & Other Important Information** |
| **If you need immediate medical attention** | Emergency room care | Medical emergency: Not available<br>Non-emergency: Not available | Medical emergency: $100 co-pay/visit plus 20% co-insurance<br>Non-emergency: $100 co-pay/visit plus 20% co-insurance | Medical emergency: $100 co-pay/visit plus 20% co-insurance<br>Non-emergency: $100 co-pay/visit plus 20% co-insurance | Co-pay waived if admitted. |
| | Emergency medical transportation | Ground: Not available<br>Air: Not available | Ground: 20% co-insurance<br>Air: 20% co-insurance | Ground: 20% co-insurance<br>Air: 20% co-insurance | Limited to nearest facility able to treat condition. Air covered if ground medically or physically inappropriate. Out-of-network air based on 200 percent of Medicare allowance. |
| | Urgent care | Not available | 20% co-insurance | 40% co-insurance | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | Not available | 20% co-insurance | 40% co-insurance | Limited to semi-private room unless intensive or coronary care units, medically necessary isolation, or hospital only has private rooms. Preauthorization required for some inpatient services. |
| | Physician/surgeon fees | Not available | 20% co-insurance | 40% co-insurance | None |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | No charge, deductible does not apply | 20% co-insurance | 40% co-insurance | None |
| | Inpatient services | Not available | 20% co-insurance | 40% co-insurance | Preauthorization required for some inpatient services. |

| What You Will Pay | | | | | |
|---|---|---|---|---|---|
| **Common Medical Event** | **Services You May Need** | **Health & Counseling Center: (You will pay the least)** | **In-network (You will pay more)** | **Out-of-network (You will pay the most)** | **Limitations, Exceptions, & Other Important Information** |
| **If you are pregnant** | Office visits | Not available | 20% co-insurance | 40% co-insurance | Cost sharing does not apply for preventive services. Practitioner delivery and hospital visits are covered under prenatal and postnatal care. Facility is covered the same as any other hospital services. Coverage includes termination of pregnancy. |
| | Childbirth/delivery professional services | | | | |
| | Childbirth/delivery facility services | | | | |
| **If you need help recovering or have other special health needs** | Home health care | Not available | 20% co-insurance | 40% co-insurance | No coverage for private duty nursing or custodial care. |
| | Rehabilitation services | Inpatient: Not available<br>Outpatient: Not available | Inpatient: 20% co-insurance<br>Outpatient: 20% co-insurance | Inpatient: 40% co-insurance<br>Outpatient: 40% co-insurance | Inpatient: Limited to 30 days/year. Preauthorization required.<br>Outpatient: Limited to 30 visits/year. No coverage for recreation therapy. |
| | Habilitation services | Inpatient: Not available<br>Outpatient: Not available | Inpatient: 20% co-insurance<br>Outpatient: 20% co-insurance | Inpatient: 40% co-insurance<br>Outpatient: 40% co-insurance | Inpatient: Limited to 30 days/year. Preauthorization required.<br>Outpatient: Limited to 30 visits/year. No coverage for recreation therapy. |
| | Skilled nursing care | Not available | 20% co-insurance | 40% co-insurance | Limited to 60 days/year. No coverage for custodial care. |
| | Durable medical equipment | No charge, deductible does not apply | 20% co-insurance | 40% co-insurance | Limited to: $5,000/year overall; one pair/year for glasses or contact lenses; one breast pump/pregnancy; one wig/year for chemotherapy or radiation therapy. Preauthorization required if equipment is over $1,000 and for power-assisted wheelchairs. |
| | Hospice services | Not available | 20% co-insurance | 40% co-insurance | No coverage for private duty nursing. |

| What You Will Pay | | | | | |
|---|---|---|---|---|---|
| **Common Medical Event** | **Services You May Need** | **Health & Counseling Center: (You will pay the least)** | **In-network (You will pay more)** | **Out-of-network (You will pay the most)** | **Limitations, Exceptions, & Other Important Information** |
| **If your child needs dental or eye care** | Children's eye exam | Not available | $20 co-pay, deductible does not apply | 50% co-insurance, deductible does not apply | For age 18 or younger, one routine eye exam/year. |
| | Children's glasses | Not available | Lenses: $40 co-pay, deductible does not apply<br>Frames: No charge up to $150 maximum then 50% co-insurance, deductible does not apply<br>Contact lenses (in lieu of glasses): $40 co-pay, deductible does not apply | 50% co-insurance, deductible does not apply | For age 18 or younger, one pair of glasses (frames and lenses) or contacts (lenses and fitting) per year. |
| | Children's dental check-up | Not available | No charge | No charge | For age 18 or younger, two routine or other diagnostic exam/year.<br>For age 18 or younger, problem focused exams are covered. |

## 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.)**

- Abortion
- Bariatric surgery
- Cosmetic surgery (except in certain situations)
- Dental care (Adult)
- Hearing aids (Adult)
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- 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
- Chiropractic care
- Hearing aids (Child)
- Non-emergency care when traveling outside the U.S.
- 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: Division of Financial Regulation at 1-888-877-4894 or at dfr.oregon.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 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: The PacificSource Customer Service team at 1-888-977-9299 or the Division of Financial Regulation at 1-888-877-4894 or at dfr.oregon.gov.

**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 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 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, copayments and coinsurance) 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** | $500 |
| **Specialist** | 20% co-insurance |
| **Hospital (facility)** | 20% co-insurance |
| **Other** | 20% co-insurance |

**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** |
|---|---|
| **In this example, Peg would pay:** | |
| *Cost Sharing* | |
| Deductibles | $500 |
| Copayments | $10 |
| Coinsurance | $2400 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$2,970** |

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

| | |
|---|---|
| **The plan's overall deductible** | $500 |
| **Specialist** | 20% co-insurance |
| **Hospital (facility)** | 20% co-insurance |
| **Other** | 20% co-insurance |

**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** |
|---|---|
| **In this example, Joe would pay:** | |
| *Cost Sharing* | |
| Deductibles | $500 |
| Copayments | $700 |
| Coinsurance | $300 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$1,520** |

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

| | |
|---|---|
| **The plan's overall deductible** | $500 |
| **Specialist** | 20% co-insurance |
| **Hospital (facility)** | 20% co-insurance |
| **Other** | 20% co-insurance |

**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** |
|---|---|
| **In this example, Mia would pay:** | |
| *Cost Sharing* | |
| Deductibles | $500 |
| Copayments | $10 |
| Coinsurance | $500 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,010** |

The **plan** would be responsible for the other costs of these EXAMPLE covered services.