UO SHIP: Comprehensive Medical–Domestic Law Students

Coverage Period: 08/10/2016– 08/09/2017

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual | **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at PacificSource.com or by calling 1-855-274-9814

Important Questions	Answers	Why this Matters:
What is the overall deductible?	University Health Center (UHC) and University Counseling and Testing Center (UCTC), University Direct Contract Network participating providers: $0 person | PacificSource Network (PSN) participating providers: $250 person | Non-participating provider: $750 person. Doesn't apply to: Preventive, Participating provider Professional, Outpatient, Ambulance, Mental Health, Inpatient room and board, non-participating provider emergency room services, and pediatric dental check-ups. Rx drugs.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 3 for how much you pay for covered services after you meet the deductible.
Are there other deductibles for specific services?	Yes. Pediatric Dental Deductible for Non-participating providers: $750. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes. University Health Center (UHC) and University Counseling and Testing Center (UCTC), University Direct Contract Network participating providers, PacificSource Network (PSN) participating providers: $3,000 person | Non-participating provider: $6,350 person	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed 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.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page two describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of preferred providers, see PacificSource.com/uo or call 1-855-274-9814.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a specialist?	No.	You can see the specialist you choose without permission from this plan.

Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 8. See your policy or plan document for additional information about excluded services.

- Copayments are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- Coinsurance is *your* share of the costs of a covered service, calculated as a percent of the allowed amount for the service. For example, if the plan's allowed amount for an overnight hospital stay is $1,000, your coinsurance payment of 20% would be $200. This may change if you haven't met your deductible.
- The amount the plan pays for covered services is based on the allowed amount. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the allowed amount is $1,000, you may have to pay the $500 difference. (This is called balance billing.)
- This plan may encourage you to use participating providers by charging you lower deductibles, copayments and coinsurance amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a University Health Center (UHC) / University Counseling and Testing Center (UCTC) Provider	Your Cost If You Use a U of O Direct Contract Participating Provider	Your Cost If You Use a PSN Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge	$20 copay/visit	$25 copay/visit + 20% coinsurance	Deductible + 30% coinsurance	---none---
	Specialist visit	No charge	$20 copay/visit	$25 copay/visit + 20% co-insurance	Deductible + 30% coinsurance	---none---
	Other practitioner office visit	No charge	Not Available	Deductible + 20% coinsurance	Deductible + 30% coinsurance	Acupuncture/Chiropractic Care: limited to a combined $1,000/contract year. No coverage for homeopathic medicines, supplies, or massage therapy.

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If you visit a health care provider's office or clinic	Preventive care/screening/ immunization	No charge Well baby/Well Child Care/ Mammogram/ Colonoscopy: Not available	No charge	No charge	Not covered	Limited to: Routine Physicals: 13 visits ages 0-36 months and once /contract year ages 3+. Well Woman Visits: annually. Immunizations: CDC and USPSTF Preventive Care Grade A and B Recommended. Preventive Colonoscopy: Ages 50-75. High Risk Colonoscopy: Under age 50.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	10% coinsurance	20% coinsurance	Deductible + 30% coinsurance	---none---
	Imaging (CT/PET scans, MRIs)	Not available	Not available	$100 copay/test + 20% coinsurance	Deductible + 30% coinsurance	Pre- authorization required.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at PacificSource.com/uo.	Generic drugs	Preventive: No charge Retail: $5 copay Mail: Not available	Preventive: No charge Retail: $15 copay Mail: $15 copay	Preventive: No charge Retail: $15 copay Mail: $15 copay	Not covered	Retail limited to 30-day supply. Mail limited to 30-day supply. Pre- authorization required for certain drugs. Select medications from the UHC/UCTC available for 90-day supply.
	Preferred brand drugs	Retail: $15 copay Mail: Not available	Retail: $25copay Mail: $25 copay	Retail: $25 copay Mail: $25 copay	Not covered	

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If you need drugs to treat your illness or condition More information about prescription drug coverage is available at PacificSource.com/uo.	Non-preferred brand drugs	Retail: $30 copay Mail: Not available	Retail: $40 copay Mail: $40 copay	Retail: $40 copay Mail: $40 copay	Not covered	Retail limited to 30-day supply. Mail limited to 30-day supply. Pre- authorization required for certain drugs. Select medications from the UHC/UCTC available for 90-day supply.
	Specialty drugs	$40 copay	$40 copay	$40 copay	Not covered	First fill via participating retail pharmacy or U of O Health Center will be covered. All subsequent fills are required to be at a participating specialty pharmacy provider. Limited to 30-day supply. Pre- authorization required for certain drugs.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not available	$100 copay/visit + 10% coinsurance	$150 copay/visit + 20% coinsurance	Deductible + 30% coinsurance	Pre- authorization required
	Physician/surgeon fees	No charge	$100 copay/ visit + 10% coinsurance	$150 copay/visit + 20% coinsurance	Deductible + 30% coinsurance	Pre- authorization required
If you need immediate medical attention	Emergency room services	Not available	$75 copay/visit + 10% coinsurance	Medical Emergency $75 copay/visit + 10% coinsurance Non-Emergency $150 copay/visit + 10% coinsurance	Medical Emergency $75 copay/visit + 10% coinsurance Non-Emergency 150 copay/visit + 30% coinsurance	Copay waived if admitted. Non- participating paid as participating if emergency medical condition.

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If you need immediate medical attention	Emergency medical transportation	Ground and Air: Not available	Ground: $50 copay/ trip Air: Not available	Ground and Air: $100 copay/trip + 20% coinsurance	Ground and Air: $100 copay/trip + Deductible + 30% coinsurance	Limited to nearest facility able to treat condition. Air covered if ground medically or physically inappropriate. Non- participating air covered up to 200% of the Medicare allowance.
	Urgent care	Not available	$20 copay/visit	$25 copay/visit + 20% coinsurance	Deductible + 30% coinsurance	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	Not available	$250 copay/admit + 10% coinsurance	$250 copay/admit+ 20% coinsurance	Deductible + 30% coinsurance	Limited to semi-private room unless intensive or coronary care units, medically necessary isolation, or hospital only has private rooms. Pre- authorization required for some inpatient services.
	Physician/surgeon fee	Not available	$100 copay/visit + 10% coinsurance	$150 copay/visit + 20% coinsurance	Deductible + 30% coinsurance	---none---
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	No charge	$20 copay/visit	$25 co-pay/visit + 20% co-insurance	Deductible + 30% coinsurance	---none---
	Mental/Behavioral health inpatient services	Not available	$250 copay/admit + 10% coinsurance	$250 copay/admit+ 20% coinsurance	Deductible + 30% coinsurance	Pre- authorization required.
	Substance use disorder outpatient services	No charge	$20 copay/visit	$25 copay/visit + 20% coinsurance	Deductible + 30% coinsurance	---none---
	Substance use disorder inpatient services	Not available	$250 copay/admit + 10% coinsurance	$250 copay/admit+ 20% coinsurance	Deductible + 30% coinsurance	Pre- authorization required.

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If you are pregnant	Prenatal and postnatal care	Not available	10% coinsurance	Deductible + 20% coinsurance	Deductible + 30% coinsurance	Preventive prenatal: No coinsurance.
	Delivery and all inpatient services	Not available	$250 copay/admit + 10% coinsurance	$250 copay/admit+ 20% coinsurance	Deductible + 30% coinsurance	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.
If you need help recovering or have other special health needs	Home health care	Not available	10% coinsurance	Deductible + 20% coinsurance	Deductible + 30% coinsurance	No coverage for private duty nursing or custodial care. Pre-authorization required.
	Rehabilitation services	Inpatient: Not available Outpatient: No charge	Inpatient: 10% coinsurance Outpatient: $20 copay/visit + 10% coinsurance	Inpatient: Deductible + 20% coinsurance Outpatient: $25 copay/visit + 20% coinsurance	Inpatient: Deductible + 30% coinsurance Outpatient: Deductible + 30% coinsurance	Inpatient: Limited to 30 days/contract year unless medically necessary to treat a mental health diagnosis. Pre- authorization required. Treatment of head or spinal cord injuries are covered for up to 60 days per contract year. Outpatient: Limited to a combined maximum of 30 visits/contract year unless medically necessary to treat a mental health diagnosis. No coverage for recreation therapy.

Common Medical Event	Services You May Need	Your Cost If You Use a University Health Center (UHC) / University Counseling and Testing Center (UCTC) Provider	Your Cost If You Use a U of O Direct Contract Participating Provider	Your Cost If You Use a PSN Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Habilitation services	Inpatient: Not available Outpatient: No charge	Inpatient: 10% coinsurance Outpatient: $20 copay/visit + 10% coinsurance	Inpatient: 20% coinsurance Outpatient: $25 copay/visit + 20% coinsurance	Inpatient: Deductible + 30% coinsurance Outpatient: Deductible + 30% coinsurance	Inpatient: Limited to 30 days/contract year unless medically necessary to treat a mental health diagnosis. Pre- authorization required. Outpatient: Limited to a combined maximum of 30 visits/contract year unless medically necessary to treat a mental health diagnosis. No coverage for recreation therapy.
	Skilled nursing care	Not available	Not available	Deductible + 20% coinsurance	Deductible + 30% coinsurance	Limited to 60 days/contract year. No coverage for custodial care. Pre- authorization required.
	Durable medical equipment	No charge	20% coinsurance	20% coinsurance	Deductible + 30% coinsurance	Limited to: $5,000/contract year; pre-authorization required for power-assisted wheelchairs; one pair/contract year for glasses or contact lenses to correct a specific vision defect from a severe medical or surgical problem; one/ear every 48 months for hearing aids; one breast pump/pregnancy; and $500/contract year for wig for chemotherapy or radiation therapy. Pre- authorization required if over $800.
	Hospice service	Not available	10% coinsurance	Deductible + 20% coinsurance	Deductible + 30% coinsurance	Pre- authorization required. No coverage for private duty nursing.
If your child needs dental or eye care	Eye exam	Not available	No charge	No charge	Deductible + 25% coinsurance	One routine eye exam/contract year through age 18 when provided by licensed provider.

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If your child needs dental or eye care	Glasses	Not available	No charge	No charge	Deductible + 25% coinsurance	One pair of lenses and frames from the Pediatric Exchange Collection/contract year or Contact lenses in lieu of eyeglasses through age 18.
	Dental check-up	No Charge	No Charge	No Charge	No Charge	Routine and problem focused dental exams are covered for members through age 18.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Bariatric surgery
- Cosmetic surgery
- Custodial care
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Massage therapy
- Non-emergency care when traveling outside the U.S. (If received in country of citizenship)
- Outpatient recreational therapy
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care, other than with diabetes mellitus

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture
- Chiropractic care
- Hearing aids
- Weight loss programs

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your premium. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

Questions: Call 1-855-274-9814 or visit us at PacificSource.com.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at PacificSource.com or call 1-855-274-9814 to request a copy.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact the PacificSource Customer Service Department at 1-855-274-9814.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." This plan or policy does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-855-274-9814.

———————————*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*———————————

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- Amount owed to providers: $7,540
- Plan pays $6,140
- Patient pays $1,400

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	$7,540

Patient pays:

Deductibles	$300
Copays	$400
Coinsurance	$500
Limits or exclusions	$200
Total	$1,400

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- Amount owed to providers: $5,400
- Plan pays $3,920
- Patient pays $1,480

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	$5,400

Patient pays:

Deductibles	$300
Copays	$900
Coinsurance	$200
Limits or exclusions	$80
Total	$1,480

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact; 1-855-274-9814.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ No. Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ Yes. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.