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, http://PacificSource.com/uo. 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 http://www.dol.gov/ebsa/healthreform or call 1-855-274-9814 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	University Health Center (UHC) participating provider: $0 person/ $0 family | UO Exclusive participating provider and PacificSource Network (PSN) participating provider: $200 person/ $600 family | Non-participating provider: $1,000 person/ $3,000 family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. All services provided by a UHC provider, if available. Preventive care; Participating provider ER visits and non-participating provider ER medical emergency visits. Participating provider: office visits, specialist visits, outpatient rehabilitation, advanced diagnostic imaging, diagnostic and therapeutic radiology/lab and dialysis, urgent care, ambulance. Rx drugs. Vision age 18 and younger - vision exam and hardware. Pediatric dental check-up age 18 and younger.	This plan covers some items and services even if you haven't yet met the annual 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 https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. Pediatric dental deductible for Non-participating provider: $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.
What is the out-of-pocket limit for this plan?	University Health Center (UHC), UO Exclusive participating provider, PacificSource Network (PSN) participating provider: $3,000 person/ $6,000 family | Non-participating provider: $6,350 person/ $12,700 family	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. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
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 http://providerdirectory.PacificSource.com/?nPlan=PSN or call 1-888-977-9299 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. 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.

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		University Health Center (UHC) Participating Provider (You will pay the least)	UO Exclusive Participating Provider (You will pay more)	PSN Participating Provider (You will pay more)	Non-participating Providers (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	No charge, deductible does not apply	$20 co-pay/visit, deductible does not apply	$35 co-pay/visit, deductible does not apply	Deductible then 40% co-insurance	None
	Specialist visit		$30 co-pay/visit, deductible does not apply	$45 co-pay/visit, deductible does not apply		
	Preventive care/screening/immunization	No charge, deductible does not apply Well baby/Well child care / Mammogram / Colonoscopy: Not available	No charge, deductible does not apply		Not covered	Routine 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 you plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge, deductible does not apply	10% co-insurance, deductible does not apply	20% co-insurance, deductible does not apply	Deductible then 40% co-insurance	None
	Imaging (CT/PET scans, MRIs)	Not available	$200 co-pay/visit, deductible does not apply	$200 co-pay/visit + 20% co-insurance, deductible does not apply		Preauthorization required.

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		University Health Center (UHC) Participating Provider (You will pay the least)	UO Exclusive Participating Provider (You will pay more)	PSN Participating Provider (You will pay more)	Non-participating Providers (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at http://PacificSource.com/uo.	Tier one drugs	Preventive: No charge, deductible does not apply Retail: $5 co-pay, deductible does not apply Mail: Not available	Preventive: No charge, deductible does not apply Retail: $15 co-pay, deductible does not apply Mail: $15 co-pay, deductible does not apply		Not covered	Retail limited to 30 day supply. Mail limited to 30 day supply. Preauthorization required for certain drugs. Select medications from the IHC/UCTC available for 90 day supply.
	Tier two drugs	Retail: $15 co-pay, deductible does not apply Mail: Not available	Retail: $25 co-pay, deductible does not apply Mail: $25 co-pay, deductible does not apply			
	Tier three drugs	Retail: $30 co-pay, deductible does not apply Mail: Not available	Retail: $40 co-pay, deductible does not apply Mail: $40 co-pay, deductible does not apply			
	Tier four specialty drugs	$40 co-pay, deductible does not apply				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. Preauthorization required for certain drugs.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not available	Deductible then 10% co-insurance	Deductible then 20% co-insurance	Deductible then 40% co-insurance	None
	Physician/surgeon fees	No charge, deductible does not apply				
If you need immediate	Emergency room services	Not available	Medical Emergency: $200	Medical Emergency: $200	Medical Emergency: $200	Co-pay waived if admitted.

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		University Health Center (UHC) Participating Provider (You will pay the least)	UO Exclusive Participating Provider (You will pay more)	PSN Participating Provider (You will pay more)	Non-participating Providers (You will pay the most)	
medical attention			co-pay, deductible does not apply Non-Emergency: $200 co-pay/visit + 10% co-insurance, deductible does not apply	co-pay, deductible does not apply Non-Emergency: $200 co-pay/visit + 20% co-insurance, deductible does not apply	co-pay, deductible does not apply Non-Emergency: Deductible then 40% co-insurance	
	Emergency medical transportation	Ground and Air: Not available	Ground: $200 co-pay/trip + 10% co-insurance, deductible does not apply Air: Not available	Ground and Air: $200 co-pay/trip + 20% co-insurance, deductible does not apply	Ground and Air: Deductible then 40% co-insurance	Limited to nearest facility able to treat condition. Air covered if ground medically or physically inappropriate. Non-participating air based on 200 percent of Medicare allowance.
	Urgent care	Not available	$30 co-pay/visit, deductible does not apply	$45 co-pay/visit, deductible does not apply	Deductible then 40% co-insurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	Not available	Deductible then 10% co-insurance	Deductible then 20% co-insurance	Deductible then 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					None
If you need mental health, behavioral health, or substance	Outpatient services	No charge, deductible does not apply	$20 co-pay/visit, deductible does not apply	$35 co-pay/visit, deductible does not apply	Deductible then 40% co-insurance	None
	Inpatient services	Not available	Deductible then 10% co-insurance	Deductible then 20% co-insurance		Preauthorization required.

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		University Health Center (UHC) Participating Provider (You will pay the least)	UO Exclusive Participating Provider (You will pay more)	PSN Participating Provider (You will pay more)	Non-participating Providers (You will pay the most)	
abuse services						
If you are pregnant	Office visits	Not available	Deductible then 10% co-insurance	Deductible then 20% co-insurance	Deductible then 40% co-insurance	Cost sharing does not apply to certain 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	Deductible then 10% co-insurance	Deductible then 20% co-insurance	Deductible then 40% co-insurance	No coverage for private duty nursing or custodial care. Preauthorization required.
	Rehabilitation services	Inpatient: Not available Outpatient: No charge, deductible does not apply	Inpatient: Deductible then 10% co-insurance Outpatient: $20 co-pay/visit , deductible does not apply	Inpatient: Deductible then 20% co-insurance Outpatient: $35, deductible does not apply	Inpatient: Deductible then 40% co-insurance Outpatient: Deductible then 40% co-insurance	Inpatient: Limited to 30 days/contract year unless medically necessary to treat a mental health diagnosis. Preauthorization 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.
	Habilitation services	Inpatient: Not available Outpatient: No charge, deductible does not apply	Inpatient: Deductible then 10% co-insurance	Inpatient: Deductible then 10% co-insurance	Inpatient: Deductible then 10% co-insurance	Inpatient: Limited to 30 days/contract year unless medically necessary to treat a mental health diagnosis. Preauthorization required.

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		University Health Center (UHC) Participating Provider (You will pay the least)	UO Exclusive Participating Provider (You will pay more)	PSN Participating Provider (You will pay more)	Non-participating Providers (You will pay the most)	
			Outpatient: $20 co-pay/visit , deductible does not apply	Outpatient: $20 co-pay/visit , deductible does not apply	Outpatient: $20 co-pay/visit , deductible does not apply	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				Limited to 60 days/contract year. No coverage for custodial care. Preauthorization required.
	Durable medical equipment	No charge, deductible does not apply	Deductible then 10% co-insurance	Deductible then 20% co-insurance	Deductible then 40% co-insurance	Limited to: $5,000/year overall; one pair/year for glasses or contact lenses; one/ear every 48 months for hearing aid; one breast pump/pregnancy; $500/year for wig for chemotherapy or radiation therapy. Preauthorization required if equipment is over $800 and for power-assisted wheelchairs.
	Hospice services	Not available				Preauthorization required. No coverage for private duty nursing.
If your child needs dental or eye care	Children's eye exam	Not available	No charge, deductible does not apply		Deductible then 25% co-insurance	One routine eye exam/year for age 18 or younger when provided by a licensed provider. For age 18 or younger, one pair of glasses (frames and lenses) or contact lenses in lieu of glasses per benefit year.
	Children's glasses					
	Children's dental check-up	No charge, deductible does not apply				Routine and problem focused dental exams are covered for members through age 18.

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.)		
• Bariatric surgery • Cosmetic surgery (except in certain situations) • 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 (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Abortion • 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 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

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 1-855-274-9814.

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 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 1-855-274-9814.

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** $200
- **Specialist** $30 co-payment
- **Hospital (facility)** 10% co-insurance
- **Other** 10% 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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$200
Copayments	$2,540
Coinsurance	$260
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,060**

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

- **The plan's overall deductible** $200
- **Specialist** $30 co-payment
- **Hospital (facility)** 10% co-insurance
- **Other** 10% 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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$200
Copayments	$2,740
Coinsurance	$60
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$3,060**

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

- **The plan's overall deductible** $200
- **Specialist** $30 co-payment
- **Hospital (facility)** 10% co-insurance
- **Other** 10% 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	**$2,500**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$70
Copayments	$1,520
Coinsurance	$10
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,600**

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