MEDICAL BENEFIT SUMMARY

Comprehensive Medical Plan
International Students

Benefit Year: UO Law Students: 8/10/2024 to 8/9/2025
UO Students (Undergraduate/Non-Law Graduate): 9/15/2024 to 9/14/2025

Who is eligible? University of Oregon Guidelines

Provider Network: UO Exclusive Network and Navigator Network

University Health Services (UHS):

If the Member is a Student of the University of Oregon, then University Health Services is considered an In-Network Provider for Covered Services. Services provided by University Health Services (UHS) are covered per University guidelines. Note: UO Students who are eligible to receive services at Portland State University - Center for Student Health and Counseling (SHAC) will receive the same level of benefits as those received at University Health Services (UHS). To receive this benefit, these Students must print an itemized statement from the SHAC Patient Portal and mail it to PacificSource (mail to: PacificSource Health Plans, Attn: Claims, P.O. Box 7068, Springfield, OR 97475-0068) for reimbursement.

Annual Deductible	Per Person, Per Benefit Year	Per Family, Per Benefit Year
University Health Services	None	None
UO Exclusive Network & Navigator Network (In-network Providers)	$300	$900
Out-of-network Providers	$1,000	$3,000
Out-of-Pocket Limit	**Per Person, Per Benefit Year**	**Per Family, Per Benefit Year**
UHS, UO Exclusive Network, and Navigator Network (In-network Providers)	$5,000	$10,000
Out-of-network Providers	$10,000	$12,700

Please note: Your actual costs for services provided by an Out-of-network Provider may exceed this Student Plan's out-of-pocket limit for out-of-network services. In addition, Out-of-network Providers may in certain circumstances bill you for the difference between the amount charged by the Provider and the amount allowed by the Student Plan (called Balance Billing), and this amount is not counted toward the out-of-network out-of-pocket limit. Even though you may have the same benefit for In-network and Out-of-network Providers, you may still be responsible for any amounts that an Out-of-network Provider charges that are over the Plan's Allowable Fee. Please see Allowable Fee and Balance Billing in the definitions section of this student guide.

In-network Provider Deductible and out-of-pocket limit accumulates separately from the Out-of-network Provider Deductible and out-of-pocket limit.

The Member is responsible for the above Deductible and the following amounts:

Service	University Health Services:	UO Exclusive Network (In-network Providers):	Navigator Network (In-network Providers):	Out-of-network Providers:
Preventive Care				
Well child exams, ages birth - 21	Not available	No Deductible, No charge	No Deductible, No charge	Not Covered
Preventive physicals	No Deductible, No charge	No Deductible, No charge	No Deductible, No charge	Not Covered
Preventive STD screening	No Deductible, No charge	No Deductible, No charge	No Deductible, No charge	Not Covered
Well woman visits	No Deductible, No charge	No Deductible, No charge	No Deductible, No charge	Not Covered
Preventive mammograms	Not available	No Deductible, No charge	No Deductible, No charge	Not Covered
Immunizations	No Deductible, No charge	No Deductible, No charge	No Deductible, No charge	Not Covered
Preventive colonoscopy	Not available	No Deductible, No charge	No Deductible, No charge	Not Covered
Professional Services				
Office and home visits	No Deductible, No charge	First three visits, no Deductible, $5. Subsequent visits, no Deductible, $25 Copay/visit***	First three visits, no Deductible, $5. Subsequent visits, no Deductible, $40 Copay/visit***	Deductible then 50% Coinsurance
Naturopath office visits	Not available	Not available	No Deductible, $40 Copay/visit	Deductible then 50% Coinsurance
Specialist office and home visits	No Deductible, No charge	No Deductible, $35 Copay/visit	No Deductible, $50 Copay/visit	Deductible then 50% Coinsurance
Telehealth	No Deductible, No charge	First three visits, no Deductible, $5. Subsequent visits, no Deductible, $25 Copay/visit***	First three visits, no Deductible, $5. Subsequent visits, no Deductible, $40 Copay/visit***	Deductible then 50% Coinsurance
Newborn Nurse Home Visits	Not available	No Deductible, No charge	No Deductible, No charge	No Deductible, No charge
Office procedures and supplies	No Deductible, No charge	Deductible then 10% Coinsurance	Deductible then 20% Coinsurance	Deductible then 50% Coinsurance
Surgery	No Deductible, No charge	Deductible then 10% Coinsurance	Deductible then 20% Coinsurance	Deductible then 50% Coinsurance

Service	University Health Services:	UO Exclusive Network (In-network Providers):	Navigator Network (In-network Providers):	Out-of-network Providers:
Outpatient Rehabilitation Services	No Deductible, No charge	No Deductible, $25 Copay/visit	No Deductible, $40 Copay/visit	Deductible then 50% Coinsurance
Outpatient Habilitation Services	No Deductible, No charge	No Deductible, $25 Copay/visit	No Deductible, $40 Copay/visit	Deductible then 50% Coinsurance
Hospital Services				
Inpatient room and board	Not available	Deductible then 10% Coinsurance	Deductible then 20% Coinsurance	Deductible then 50% Coinsurance
Inpatient Rehabilitation Services	Not available	Deductible then 10% Coinsurance	Deductible then 20% Coinsurance	Deductible then 50% Coinsurance
Inpatient Habilitation Services	Not available	Deductible then 10% Coinsurance	Deductible then 20% Coinsurance	Deductible then 50% Coinsurance
Skilled Nursing Facility care	Not available	Not available	Deductible then 20% Coinsurance	Deductible then 50% Coinsurance
Outpatient Services				
Outpatient surgery/services	Not available	Deductible then 10% Coinsurance	Deductible then 20% Coinsurance	Deductible then 50% Coinsurance
Diagnostic Imaging (advanced)	No Deductible, No charge	Deductible then 10% Coinsurance	Deductible then 20% Coinsurance	Deductible then 50% Coinsurance
Diagnostic and therapeutic radiology/laboratory and dialysis - (non-advanced)	No Deductible, No charge+	Deductible then 10% Coinsurance	Deductible then 20% Coinsurance	Deductible then 50% Coinsurance
Urgent and Emergency Services				
Urgent care center visits	Not available	No Deductible, $50 Copay/visit	No Deductible, $75 Copay/visit	Deductible then 50% Coinsurance
Emergency room visits – medical emergency	Not available	No Deductible, $300 Copay/visit^	No Deductible, $300 Copay/visit^	No Deductible, $300 Copay/visit^
Emergency room visits – non-emergency	Not available	No Deductible, $300 Copay/visit then 10% Coinsurance^	No Deductible, $300 Copay/visit then 20% Coinsurance^	Deductible then 50% Coinsurance

Service	University Health Services:	UO Exclusive Network (In-network Providers):	Navigator Network (In-network Providers):	Out-of-network Providers:
Ambulance, ground	Not available	No Deductible, $300 Copay/trip then 10% Coinsurance	No Deductible, $300 Copay/trip then 20% Coinsurance	Deductible then 50% Coinsurance
Ambulance, air	Not available	Not available	No Deductible, $300 Copay/trip then 20% Coinsurance	Deductible then 50% Coinsurance
Maternity Services **				
Physician/Provider services (Global Charge)	Not available	Deductible then 10% Coinsurance	Deductible then 20% Coinsurance	Deductible then 50% Coinsurance
Hospital/Facility services	Not available	Deductible then 10% Coinsurance	Deductible then 20% Coinsurance	Deductible then 50% Coinsurance
Mental Health and Substance Use Disorder Services*				
Office visits	No Deductible, No charge	First three visits, no Deductible, $5. Subsequent visits, no Deductible, $25 Copay/visit***	First three visits, no Deductible, $5. Subsequent visits, no Deductible, $40 Copay/visit***	Deductible then 50% Coinsurance
Inpatient care	Not available	Deductible then 10% Coinsurance	Deductible then 20% Coinsurance	Deductible then 50% Coinsurance
Residential programs	Not available	Not available	Deductible then 20% Coinsurance	Deductible then 50% Coinsurance
Other Covered Services				
Allergy injections	Not available	Deductible then 10% Coinsurance	Deductible then 20% Coinsurance	Deductible then 50% Coinsurance
Durable Medical Equipment	No Deductible, No charge+	Deductible then 10% Coinsurance	Deductible then 20% Coinsurance	Deductible then 50% Coinsurance
Home Healthcare	Not available	Deductible then 10% Coinsurance	Deductible then 20% Coinsurance	Deductible then 50% Coinsurance
Acupuncture	No Deductible, No charge	No Deductible, $25 Copay/visit	No Deductible, $40 Copay/visit	Deductible then 50% Coinsurance
Chiropractic manipulation/spinal manipulation	Not available	Not available	No Deductible, $40 Copay/visit	Deductible then 50% Coinsurance

Service	University Health Services:	UO Exclusive Network (In-network Providers):	Navigator Network (In-network Providers):	Out-of-network Providers:
Transplants	Not available	Not available	Deductible then 20% Coinsurance	Deductible then 50% Coinsurance

This is a brief summary of benefits. Refer to your student guide for additional information or a further explanation of benefits, limitations, and exclusions.

^ Copay applies to ER physician and facility charges only. Copay waived if admitted into Hospital.

** Medically Necessary services, medication, and supplies to manage diabetes during pregnancy from conception through six weeks postpartum will not be subject to a Deductible, Copayment, or Coinsurance.

+ Some services at UHS are provided by a partner entity. If a Student receives a service through these external partners, the Student will receive a bill directly from that partner entity and normal Deductibles and Copays and/or Coinsurance will apply according to the tiered benefits noted above.

* This Student Plan complies with all federal laws and regulations related to the Mental Health Parity and Addiction Equity Act of 2008. Cost-sharing for Mental Health and Substance Use Disorder Services will be paid at the same cost-sharing as those Medical/Surgical benefits that fall within the same classification and sub-classification. Please contact the PacificSource Customer Service Team or the UO Student Health Benefits Team with questions.

*** First three visits per Benefit Year combined for Professional Services – Office and Home Visits, Telehealth Visits, and Mental Health and Substance Use Disorder Services – Office Visits.

Additional information

What is the annual Deductible?

This Student Plan's Deductible is the amount of money that you pay first, before this Student Plan starts to pay. You'll see that many services, especially preventive care, are covered by the Student Plan without you needing to meet the Deductible. The individual Deductible applies if you enroll without Dependents. If you and one or more Dependents enroll, the individual Deductible applies for each Member only until the family Deductible has been met.

Note that there is a separate category for In-network and Out-of-network Providers when it comes to meeting your Deductible. Only In-network Provider expense applies to the In-network Provider Deductible, and only Out-of-network Provider expense applies to the Out-of-network Provider Deductible.

What is the out-of-pocket limit?

The out-of-pocket limit is the most you'll pay for Covered Services during the Benefit Year. Once the out-of-pocket limit has been met, the Student Plan will pay 100 percent of allowed amounts for Covered Services for the rest of that Benefit Year. The individual out-of-pocket limit applies only if you enroll without dependents. If you and one or more dependents enroll, the individual out-of-pocket limit applies for each Member only until the family out-of-pocket limit has been met.

Note that there is a separate category for In-network and Out-of-network Providers when it comes to meeting your out-of-pocket limit. Only In-network Provider expense applies to the In-network

Provider out-of-pocket limit, and only Out-of-network Provider expense applies to the Out-of-network Provider out-of-pocket limit.

Payments to Providers

Payment to Providers is based on the prevailing Allowable Fee for Covered Services. In-network Providers accept the Allowable Fee as payment in full. Out-of-network Providers are allowed to Balance Bill any remaining balance that your Student Plan did not cover. Services of Out-of-network Providers could result in out-of-pocket expense in addition to the percentage indicated above.

Prior authorization

Coverage of certain medical services and Surgical Procedures requires a Benefit Determination by PacificSource before the services are performed. This process is called prior authorization. Prior authorization is necessary to determine if certain services and supplies are covered under this Student Plan, and if you meet the Student Plan's eligibility requirements. Prior authorization does not change your out-of-pocket expense for In-network and Out-of-network Providers. You'll find the most current prior authorization list on our website, PacificSource.com/uo.

Discrimination is against the law

Both the University of Oregon and PacificSource Health Plans comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. University of Oregon and PacificSource do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

PHARMACY BENEFIT SUMMARY

Comprehensive Pharmacy Plan
International Students

Benefit Year: UO Law Students: 8/10/2024 to 8/9/2025
UO Students (Undergraduate/Non-Law Graduate): 9/15/2024 to 9/14/2025

Formulary: **Oregon Drug List (ODL)**

This Student Plan includes coverage for Prescription Drugs and certain other pharmaceuticals, subject to the information below. This benefit includes some drugs required by federal healthcare reform. To check which tier your prescription falls under, call PacificSource Customer Service or visit PacificSource.com/uo.

The amount you pay for covered prescriptions at in-network pharmacies applies toward this Student Plan's in-network medical out-of-pocket limit, which is shown on the Medical Benefit Summary. The Copayment and/or Coinsurance for Prescription Drugs obtained from an in-network pharmacy are waived during the remainder of the Benefit Year in which you have satisfied the medical out-of-pocket limit.

Affordable Care Act Standard Preventive No-cost Drug List

The prescription benefit includes preventive care drugs at no cost and are not subject to a Deductible or MAC penalties. This benefit includes some drugs required by the Affordable Care Act, including tobacco cessation drugs. These drugs are identified on the Drug List as Tier 0.

PacificSource Expanded (Preventive) No-cost Drug List

The prescription benefit includes certain outpatient drugs as a preventive benefit at no charge. This includes specific drugs that are taken regularly to prevent a disease or to keep a specific disease or condition from progressing. Preventive drugs are taken to help avoid many illnesses and conditions. You can get a list of covered preventive drugs by contacting the PacificSource Customer Service team or visit PacificSource.com/uo to view the PacificSource Expanded (Preventive) No-Cost Drug List.

Contraceptives

Contraceptives approved by the Food and Drug Administration (FDA) are covered as recommended by the Health Resources and Services Administration (HRSA), U.S. Preventive Services Task Force (USPSTF), and the Centers for Disease Control and Prevention (CDC). Any Deductibles, Copayments, and/or Coinsurance amounts are waived if filled at an in-network pharmacy.

If an initial three month supply is tried, then a 12 month refill of the same contraceptive is covered at an in-network pharmacy in accordance with pharmacy benefits, regardless if the initial prescription was filled under this Student Plan.

Each time a covered prescription is dispensed, you are responsible for the amounts below:

Service/Supply	Preventive Drugs:	Tier 1:	Tier 2:	Tier 3:	Tier 4:
University Health Services Pharmacy (UHS)					
Up to a 30 day supply:	No Deductible, No charge	No Deductible, $10 Copay>	No Deductible, $25 Copay*	No Deductible, $50 Copay*	Deductible then 50% Coinsurance
In-network Retail Pharmacy					
Up to a 30 day supply:	No Deductible, No charge	No Deductible, $15 Copay	No Deductible, $50 Copay*	No Deductible, $75 Copay*	Deductible then 50% Coinsurance
In-network Mail Order Pharmacy					
Up to a 30 day supply:	No Deductible, No charge	No Deductible, $15 Copay	No Deductible, $50 Copay*	No Deductible, $75 Copay*	Deductible then 50% Coinsurance
Out-of-network Pharmacy					
Regardless of tier or day(s) supply:	Not Covered				
Compound Drugs – In-network Retail or Mail Order Pharmacy**					
Up to a 30 day supply:	Deductible then 50% Coinsurance				

>Select medications available for a 90 day supply.

**In-network formulary prescription insulin will not be subject to a Deductible and limited to $85 per 30 day supply.*

***Compounded medications are subject to a prior authorization process. Compounds are generally covered only when all commercially available formulary products have been exhausted and all the ingredients in the compounded medications are on the applicable formulary.*

Specialty is covered for the first fill via in-network retail pharmacy and UHS. All subsequent fills must be done through the in-network Specialty Pharmacy Providers.

MAC B - Unless the prescribing Provider requires the use of a brand name drug, the prescription will automatically be filled with a Generic Drug when available and permissible by state law. If you receive a brand name drug when a Generic is available, you will be responsible for the brand name drug's Copayment and/or Coinsurance plus the difference in cost between the brand name drug and its Generic equivalent. If your prescribing Provider requires the use of a brand name drug, the prescription will be filled with the brand name drug and you will be responsible for the brand name drug's Copayment and/or Coinsurance. The cost difference between the brand name and Generic Drug does not apply toward the medical out-of-pocket limit. This does not apply to formulary tobacco cessation medications or bowel prep kits covered under USPSTF guidelines.

See the student guide for important information about your Prescription Drug benefit, including which drugs are covered, limitations, and more.

PEDIATRIC VISION BENEFIT SUMMARY

Pediatric Vision

Benefit Year: UO Law Students: 8/10/2024 to 8/9/2025
UO Students (Undergraduate/Non-Law Graduate): 9/15/2024 to 9/14/2025

The following shows the vision benefit available under this Student Plan for all vision exams, lenses, and frames when performed or prescribed by a licensed ophthalmologist or licensed optometrist. Coverage for pediatric services will end on the last day of the month in which the enrolled Member turns 19. Medical Deductible, Copayment and/or Coinsurance for Covered Services apply to the medical out-of-pocket limit.

Service/Supply	In-network Providers	Out-of-network Providers:
Enrolled Members Age 18 and Younger		
Eye exam	No Deductible, No charge	Medical Deductible then 25% Coinsurance
Vision hardware or Contact Lenses	No Deductible, No charge for one pair per Benefit Year for frames or lenses	Medical Deductible then 25% Coinsurance for frames or lenses

Benefit Limitations: enrolled Members age 18 and younger

- One routine ophthalmologic exam with refraction, as well as dilation every Benefit Year.
- One pair of glasses (lenses and frames) per Benefit Year or contacts (lenses and fitting) in lieu of eyeglasses.
    - Lens coverage includes the following:
        - Glass or plastic lenses;
        - All lens powers (single vision, bifocal, trifocal, lenticular); and
        - Fashion and gradient tinting, oversized and glass-grey #3 prescription sunglass lenses, as well as polycarbonate lenses, anti-reflective and scratch resistant coatings.
    - Contact lens coverage includes the following:
        - Medically Necessary contact lenses for Keratoconus, Pathological Myopia, Aphakia, Anisometropia, Aniseikonia, Aniridia, Corneal Disorders, Post-traumatic Disorders, Irregular Astigmatism; and
        - Low Vision services.

Exclusions

- Lenses, frames, or contact lenses, for enrolled Members age 19 and older.
- Special procedures such as orthoptics or vision training.

- Special supplies such as non-prescription sunglasses and subnormal vision aids.
- Plano contact lenses.
- Replacement of lost, stolen, or broken lenses or frames.
- Duplication of spare eyeglasses or any lenses or frames.
- Non-prescription lenses.
- Visual analysis that does not include refraction.
- Services or supplies not listed as Covered Services.
- Eye exams required as a condition of employment, required by a labor agreement or government body.
- Expenses covered under any worker's compensation law.
- Services or supplies received before this plan's coverage begins or after it ends.
- Charges for services or supplies covered in whole or in part under any medical or vision benefits provided by the employer.
- Medical or surgical treatment of the eye.

Important information about the vision benefits

This Student Plan includes coverage for vision services. To make the most of those benefits, it is important to keep in mind the following:

In-network Providers

PacificSource is able to add value to the vision benefits by contracting with a network of vision Providers. Those Providers offer vision services at discounted rates, which are passed on to Members in the benefits.

Paying for Services

Members should remember to show their current PacificSource ID card whenever they use their vision benefits. The PacificSource Provider contracts require In-network Providers to bill PacificSource directly whenever Members receive Covered Services and supplies. Providers will verify Member vision benefits. In-network Providers should not ask Members to pay the full cost in advance. They may only collect the member's share of the expense up front, such as Copayments and amounts over the Student Plan's allowances. If Members are asked to pay the entire amount in advance, they should tell the Provider they understand the Provider has a contract with PacificSource and the Provider should bill PacificSource directly.

Sales and Special Promotions

Vision retailers often use coupons and promotions to bring in new business, such as free eye exams, two-for-one glasses, or free lenses with purchase of frames. Because In-network Providers already discount their services through their contract with PacificSource, this Student Plan's In-network Provider benefits cannot be combined with any other discounts or coupons. Members can use the Student Plan's In-network Provider benefits, or use their Out-of-network Provider benefits to take

advantage of a sale or coupon offer. If Members do take advantage of a special offer, the In-network Provider may treat them as an uninsured customer and require full payment in advance. Members can then send the claim to PacificSource themselves, and be reimbursed according to their Out-of-network Provider benefits.

PEDIATRIC DENTAL BENEFIT SUMMARY

Comprehensive Pediatric Dental Plan
International Students

Benefit Year: UO Law Students: 8/10/2024 to 8/9/2025
UO Students (Undergraduate/Non-Law Graduate): 9/15/2024 to 9/14/2025

Who is eligible? University of Oregon Guidelines

Provider Network: UO Exclusive Network

University Health Services (UHS):

If the Member is a Student of the University of Oregon, then University Health Services is considered an In-network Provider for Covered Services. Services provided by University Health Services (UHS) are covered per University guidelines. This Student Plan covers the following services when performed by a licensed Dentist, dental hygienist or denturist to the extent that they are operating within the scope of their license as required under the law in the state of issuance, and when determined to be necessary, usual, and customary by the standards of generally accepted dental practice for the prevention or treatment of oral disease or for Accidental Injury, including masticatory function (chewing of food).

This Student Plan covers dental services for enrolled individuals age 18 and younger as required under the Affordable Care Act. Coverage for pediatric services will end on the last day of the month in which the enrolled individual turns 19.

Annual Deductible	Per Person, Per Benefit Year
All Providers	$150
Out-of-Pocket Limit	
See your Medical Benefit Summary.	

The Member is responsible for any amounts shown above, in addition to the following amounts.

Service	University Health Services (UHS)	UO Exclusive Network (In-network Providers)	Out-of-network Providers
Class I Services (Covered for enrolled individuals age 18 and younger.)			
Examinations (During regular office hours)	No Deductible, No charge	No Deductible, No charge	No Deductible, No charge
Examinations (after hours)	Not available	No Deductible, 30% Coinsurance	Deductible then 40% Coinsurance
Bitewing films, full mouth X-rays, cone beam X-rays, and/or panorex	No Deductible, No charge	No Deductible, No charge	No Deductible, No charge
Dental cleaning (Prophylaxis)	No Deductible, No charge	No Deductible, No charge	No Deductible, No charge
Dental cleaning (Periodontal Maintenance)	No Deductible, No charge	No Deductible, No charge	No Deductible, No charge

Fluoride (topical and varnish applications)	No Deductible, No charge	No Deductible, No charge	No Deductible, No charge
Space maintainers	Not available	No Deductible, 50% Coinsurance	Deductible then 50% Coinsurance
Sealants	No Deductible, No charge	No Deductible, No charge	No Deductible, No charge
Class II Services (Covered for enrolled individuals age 18 and younger.)			
Fillings	Deductible then 20% Coinsurance	Deductible then 30% Coinsurance	Deductible then 40% Coinsurance
Simple extractions	Deductible then 20% Coinsurance	Deductible then 30% Coinsurance	Deductible then 40% Coinsurance
Periodontal Scaling and Root Planing	Deductible then 20% Coinsurance	Deductible then 30% Coinsurance	Deductible then 40% Coinsurance
Brush biopsies	Deductible then 20% Coinsurance	Deductible then 30% Coinsurance	Deductible then 40% Coinsurance
Crown re-cement	Deductible then 20% Coinsurance	Deductible then 30% Coinsurance	Deductible then 40% Coinsurance
Full mouth debridement	Deductible then 20% Coinsurance	Deductible then 30% Coinsurance	Deductible then 40% Coinsurance
Pulp capping	Deductible then 20% Coinsurance	Deductible then 30% Coinsurance	Deductible then 40% Coinsurance
Pulpotomy	Deductible then 20% Coinsurance	Deductible then 30% Coinsurance	Deductible then 40% Coinsurance
Palliative Care	Deductible then 20% Coinsurance	Deductible then 30% Coinsurance	Deductible then 40% Coinsurance
Anti-Microbial Agents	Deductible then 20% Coinsurance	Deductible then 30% Coinsurance	Deductible then 40% Coinsurance
Diagnostic Casts	Deductible then 20% Coinsurance	Deductible then 30% Coinsurance	Deductible then 40% Coinsurance
Denture relines	Deductible then 20% Coinsurance	Deductible then 30% Coinsurance	Deductible then 40% Coinsurance
Alveoloplasty	Deductible then 20% Coinsurance	Deductible then 30% Coinsurance	Deductible then 40% Coinsurance
Core build-up	Deductible then 20% Coinsurance	Deductible then 30% Coinsurance	Deductible then 40% Coinsurance
Tooth desensitization	Deductible then 20% Coinsurance	Deductible then 30% Coinsurance	Deductible then 40% Coinsurance
Pin retention of fillings	Deductible then 20% Coinsurance	Deductible then 30% Coinsurance	Deductible then 40% Coinsurance
Nitrous Oxide	Not available	Deductible then 30% Coinsurance	Deductible then 40% Coinsurance
Class III Services (Covered for enrolled individuals age 18 and younger.)			
Crowns	Deductible then 40% Coinsurance	Deductible then 50% Coinsurance	Deductible then 50% Coinsurance
Root canal therapy	Deductible then 40% Coinsurance	Deductible then 50% Coinsurance	Deductible then 50% Coinsurance

Complicated oral surgery	Deductible then 40% Coinsurance	Deductible then 50% Coinsurance	Deductible then 50% Coinsurance
Bridges	Deductible then 40% Coinsurance	Deductible then 50% Coinsurance	Deductible then 50% Coinsurance
Periodontal surgery	Deductible then 40% Coinsurance	Deductible then 50% Coinsurance	Deductible then 50% Coinsurance
Implants	Deductible then 40% Coinsurance	Deductible then 50% Coinsurance	Deductible then 50% Coinsurance
Replacement of existing Prosthetic Device	Deductible then 40% Coinsurance	Deductible then 50% Coinsurance	Deductible then 50% Coinsurance
Veneers	Deductible then 40% Coinsurance	Deductible then 50% Coinsurance	Deductible then 50% Coinsurance
Night guards	Deductible then 40% Coinsurance	Deductible then 50% Coinsurance	Deductible then 50% Coinsurance
Dentures	Deductible then 40% Coinsurance	Deductible then 50% Coinsurance	Deductible then 50% Coinsurance
Bone grafting	Not available	Deductible then 50% Coinsurance	Deductible then 50% Coinsurance
Orthodontia for Medically Necessary reasons for enrolled individuals age 18 and younger	Not available	Deductible then 50% Coinsurance	Deductible then 50% Coinsurance

This is a brief summary of benefits. Refer to the student guide for additional information or a further explanation of benefits, limitations, and exclusions.

Additional information

What is the annual Deductible?

This Student Plan's dental Deductible is the amount of money that Members pay first, before this Student Plan starts to pay. Members will see that some services are covered by this Student Plan without their needing to meet the Deductible.

University Health Services, UO Exclusive Network, and out-of-network expenses apply together toward the dental Deductible.

What is the out-of-pocket limit?

The out-of-pocket limit is the most a Member will pay for Covered Services during the Benefit Year. Once the out-of-pocket limit has been met, the Student Plan will pay 100 percent of allowed amounts for Covered Services for the rest of that Benefit Year. Members should be sure to check the student guide, as there are some charges, such as non-Essential Health Benefits, penalties and Balance Billed amounts that do not count toward the out-of-pocket limit.

Note that there is a separate category for In-network and Out-of-network Providers when it comes to meeting the out-of-pocket limit. Only In-network Provider expense applies to the In-network Provider out-of-pocket limit. Only Out-of-network Provider expense applies to the Out-of-network Provider out-of-pocket limit.

Payments to Providers

Payment to Providers is based on the prevailing or contracted PacificSource fee allowance for Covered Services. In-network Providers accept the fee allowance as payment in full. Out-of-network Providers are allowed to Balance Bill any remaining balance that this Student Plan did not cover. Services of Out-of-network Providers could result in out-of-pocket expense in addition to the percentage indicated above.

Prior authorization

Coverage of certain services and Surgical Procedures requires a Benefit Determination by PacificSource before the services are performed. This process is called prior authorization. Prior authorization is necessary to determine if certain services and supplies are covered under this Student Plan, and if you meet the Student Plan's eligibility requirements. Prior authorization does not change your out-of-pocket expense for In-network and Out-of-network Providers. You'll find the most current prior authorization list on our website, PacificSource.com/uo.

Discrimination is against the law

Both the University of Oregon and PacificSource Health Plans comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. University of Oregon and PacificSource do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.