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, visit 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 at Healthcare.gov/SBC-Glossary/ or call 1-855-274-9814 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	University Health Services (UHS) in-network provider: $0 individual | UO Exclusive in-network provider and Navigator in-network provider: $300 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. All services provided by a UHS provider, if available. Preventive care; In-network provider emergency room care visits and out-of-network provider emergency room care medical emergency visits. In-network provider: office visits, specialist visits, outpatient rehabilitation services, outpatient habilitation services, urgent care, ambulance. Prescription drug coverage: Tier one drugs, Tier two drugs, Tier three drugs. In-network provider: 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 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: $150. 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 Services (UHS), UO Exclusive in-network provider, Navigator in-network provider: $5,000 individual | out-of-network provider: $10,000 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 http://providerdirectory.PacificSource.com/?nPlan=Navigator or call 1-855-274-9814 for a list of network providers.	This plan uses a provider network. You pay the least if you use a provider in the UHS network. You pay more if you use a provider in the UO Exclusive network. You pay more if you use a provider in the Navigator 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 Services (UHS) In-network Provider (You will pay the least)	UO Exclusive In-network Provider (You will pay more)	Navigator In-network Provider (You will pay more)	Out-of-network 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	First 3 visits $5 co-pay/visit, deductible does not apply. Subsequent visit, $25 co-pay/ visit, deductible does not apply	First 3 visits $5 co-pay/visit, deductible does not apply. Subsequent visit, $40 co-pay/visit, deductible does not apply	50% coinsurance	First 3 visits/benefit year combined for primary care, mental health, behavioral health, and substance abuse visits.
	Specialist visit	No charge, deductible does not apply	$35 co-pay/visit, deductible does not apply	$50 co-pay/visit, deductible does not apply	50% coinsurance	
	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	No charge, deductible does not apply	Not covered	Preventive Physicals: annually. 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.
If you have a test	Diagnostic test (x-ray, blood work)	No charge, deductible does not apply	10% coinsurance	20% coinsurance	50% coinsurance	Some UHS In-network provider services 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, co-pays and/or coinsurance will apply according to the tiered benefits.

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		University Health Services (UHS) In-network Provider (You will pay the least)	UO Exclusive In-network Provider (You will pay more)	Navigator In-network Provider (You will pay more)	Out-of-network Providers (You will pay the most)	
	Imaging (CT/PET scans, MRIs)	No charge, deductible does not apply	10% coinsurance	20% coinsurance	50% coinsurance	Preauthorization is required. If not received, you will be responsible for the expenses.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at http://PacificSource.com/uo.	Generic drugs - Tier 1	Preventive: No charge, deductible does not apply Retail: $10 co-pay /prescription, deductible does not apply Mail order: Not available	Preventive: No charge, deductible does not apply $15 co-pay /prescription, deductible does not apply (retail & mail order)	Preventive: No charge, deductible does not apply $15 co-pay /prescription, deductible does not apply (retail & mail order)	Not covered	Prescription benefit includes certain outpatient drugs as a preventive benefit at no charge, when received in-network, deductible does not apply. In-network prescription insulin is not subject to a deductible and is limited to $35 per 30 day supply. Retail limited to 30 day supply. Mail order limited to 30 day supply. Preauthorization is required for certain drugs. If not received, you will be responsible for the expenses. Select medications from the UHS available for 90 day supply. Specialty drugs: First fill via in-network retail pharmacy or University Health Services will be covered. All subsequent fills are required to be at an in-network specialty pharmacy provider. Limited to 30 day supply.
	Preferred drugs - Tier 2	Retail: $25 co-pay /prescription, deductible does not apply Mail order: Not available	$50 co-pay /prescription, deductible does not apply (retail and mail order)	$50 co-pay /prescription, deductible does not apply (retail and mail order)	Not covered	
	Non-preferred drugs - Tier 3	Retail: $50 co-pay /prescription, deductible does not apply Mail order: Not available	$75 co-pay /prescription, deductible does not apply (retail and mail order)	$75 co-pay /prescription, deductible does not apply (retail and mail order)	Not covered	
	Specialty drugs – Tier 4	Retail: 50% coinsurance Mail order: Not available	50% coinsurance (retail and mail order)	50% coinsurance (retail and mail order)	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not available	10% coinsurance	20% coinsurance	50% coinsurance	Preauthorization is required for some surgeries. If not received, you will be responsible for the expenses.
	Physician/surgeon fees	No charge, deductible does not apply	10% coinsurance	20% coinsurance	50% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		University Health Services (UHS) In-network Provider (You will pay the least)	UO Exclusive In-network Provider (You will pay more)	Navigator In-network Provider (You will pay more)	Out-of-network Providers (You will pay the most)	
If you need immediate medical attention	Emergency room care	Not available	Medical Emergency: $300 co-pay/visit, deductible does not apply Non-Emergency: $300 co-pay/visit, + 10% coinsurance, deductible does not apply	Medical Emergency: $300 co-pay/visit, deductible does not apply Non-Emergency: $300 co-pay/visit, + 20% coinsurance, deductible does not apply	Medical Emergency: $300 co-pay/visit, deductible does not apply Non-Emergency: 50% coinsurance	Co-pay waived if admitted.
	Emergency medical transportation	Ground and Air: Not available	Ground: $300 co-pay/trip + 10% coinsurance, deductible does not apply Air: Not available	Ground and Air: $300 co-pay/trip + 20% coinsurance, deductible does not apply	Ground and Air: 50% coinsurance	Limited to nearest facility able to treat condition. Air covered if ground medically or physically inappropriate.
	Urgent care	Not available	$50 co-pay/visit, deductible does not apply	$75 co-pay/visit, deductible does not apply	50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	Not available	10% coinsurance	20% coinsurance	50% coinsurance	Limited to semi-private room, except when a private room is determined necessary.. Preauthorization is required for some inpatient services. If not received, you will be responsible for the expenses.
	Physician/surgeon fees	Not available	10% coinsurance	20% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance	Outpatient services	No charge, deductible does not apply	First 3 visits $5 co-pay/visit, deductible does not apply. Subsequent visit, $25 co-pay/visit, deductible does not apply	First 3 visits $5 co-pay/visit, deductible does not apply. Subsequent visit, $40 co-pay/visit,	50% coinsurance	First 3 visits/benefit year combined for primary care, mental health, behavioral health, and substance abuse visits.

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		University Health Services (UHS) In-network Provider (You will pay the least)	UO Exclusive In-network Provider (You will pay more)	Navigator In-network Provider (You will pay more)	Out-of-network Providers (You will pay the most)	
abuse services				deductible does not apply		
	Inpatient services	Not available	10% coinsurance	20% coinsurance	50% coinsurance	Preauthorization is required for some inpatient services. If not received, you will be responsible for the expenses.
If you are pregnant	Office visits	Not available	10% coinsurance	20% coinsurance	50% coinsurance	Cost sharing does not apply to certain preventive services. 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	Not available	10% coinsurance	20% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	Not available	10% coinsurance	20% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	Not available	10% coinsurance	20% coinsurance	50% coinsurance	No coverage for private duty nursing or custodial care.
	Rehabilitation services	Inpatient: Not available Outpatient: No charge, deductible does not apply	Inpatient: 10% coinsurance Outpatient: $25 co-pay/visit, deductible does not apply	Inpatient: 20% coinsurance Outpatient: $40 co-pay/visit, deductible does not apply	Inpatient and Outpatient: 50% coinsurance	Inpatient: Limited to 30 days/benefit year. Recreation therapy is covered as part of the inpatient admission. Outpatient: No coverage for recreation therapy. Limited to a combined maximum of 30 visits/benefit year.
	Habilitation services	Inpatient: Not available Outpatient: No charge, deductible does not apply	Inpatient: 10% coinsurance Outpatient: $25 co-pay/visit, deductible does not apply	Inpatient: 20% coinsurance Outpatient: $40 co-pay/visit, deductible does not apply	Inpatient and Outpatient: 50% coinsurance	Inpatient: Limited to 30 days/benefit year. Recreation therapy is covered as part of the inpatient admission. Outpatient: No coverage for recreation therapy. Limited to a combined maximum of 30 visits/benefit year.
	Skilled nursing care	Not available	Not available	20% coinsurance	50% coinsurance	Limited to 60 days/benefit year. No coverage for custodial care.

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		University Health Services (UHS) In-network Provider (You will pay the least)	UO Exclusive In-network Provider (You will pay more)	Navigator In-network Provider (You will pay more)	Out-of-network Providers (You will pay the most)	
	Durable medical equipment	No charge, deductible does not apply	10% coinsurance	20% coinsurance	50% coinsurance	Limited to: $5,000/benefit year overall if not an essential health benefit; one pair/benefit year for glasses or contact lenses; one breast pump/pregnancy; one wig/benefit year for chemotherapy or radiation therapy. Hearing aids are limited to one per hearing impaired ear every 36 months or more frequently if modification to an existing hearing aid will not meet the needs of the member. Some UHS In-network provider services 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, co-pays and/or coinsurance will apply according to the tiered benefits. Preauthorization required if equipment is over $2,500 and for power-assisted wheelchairs. If not received, you will be responsible for the expenses.
	Hospice services	Not available	10% coinsurance	20% coinsurance	50% coinsurance	No coverage for private duty nursing. Respite care limited to 30 days/lifetime.
If your child needs dental or eye care	Children's eye exam	Not available	No charge, deductible does not apply	No charge, deductible does not apply	25% coinsurance	One routine eye exam/benefit 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 contacts (lenses and fitting) in lieu of glasses per benefit year.
	Children's glasses	Not available	No charge, deductible does not apply	No charge, deductible does not apply	25% coinsurance	
	Children's dental check-up	No charge, deductible does not apply	No charge, deductible does not apply	No charge, deductible does not apply	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 (Acupuncture is limited to 12 visits per benefit year.) • Chiropractic care (Chiropractic care is limited to 20 visits per benefit year.)	• Hearing aids (Hearing aids are limited to one per hearing impaired ear every 36 months or more frequently if modification to an existing hearing aid will not meet the needs of the member.)	• 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.
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 1-855-274-9814.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-281-1464.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-866-281-1464.

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** $300
- **Specialist copayment** $0
- **Hospital (facility) coinsurance** 10%
- **Other coinsurance** 10%

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	$300
Copayments	$10
Coinsurance	$1,100
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,470**

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

- **The plan's overall deductible** $300
- **Specialist copayment** $0
- **Hospital (facility) coinsurance** 10%
- **Other copayment** $25

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	$0
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$520**

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

- **The plan's overall deductible** $300
- **Specialist copayment** $0
- **Hospital (facility) coinsurance** 10%
- **Other copayment** $300

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic tests (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost sharing	
Deductibles	$40
Copayments	$800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$840**

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