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.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What is the overall deductible?</strong></td>
<td>University Health Center (UHC) in-network provider: $0 person/ $0 family</td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td>UO Exclusive in-network provider and PacificSource Network (PSN) in-network provider: $300 person/ $900 family</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Out-of-network provider: $1,000 person/ $3,000 family</td>
<td></td>
</tr>
<tr>
<td><strong>Are there services covered before you meet your deductible?</strong></td>
<td>Yes. All services provided by a UHC provider, if available. Preventive care; In-network provider ER visits and out-of-network provider ER medical emergency visits. In-network 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.</td>
<td>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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</td>
</tr>
<tr>
<td><strong>Are there other deductibles for specific services?</strong></td>
<td>Yes. Pediatric dental deductible: $150. There are no other specific deductibles.</td>
<td>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.</td>
</tr>
<tr>
<td><strong>What is the out-of-pocket limit for this plan?</strong></td>
<td>University Health Center (UHC), UO Exclusive in-network provider, PacificSource Network (PSN) in-network provider: $5,000 person/ $10,000 family</td>
<td>The out-of-pocket limit is the most you could pay in a year for 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.</td>
</tr>
<tr>
<td></td>
<td>Out-of-network provider: $10,000 person/ $12,700 family</td>
<td></td>
</tr>
<tr>
<td><strong>What is not included in the out-of-pocket limit?</strong></td>
<td>Premiums, balance-billing charges, and health care this plan doesn’t cover.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td><strong>Will you pay less if you use a network provider?</strong></td>
<td>Yes. See <a href="http://providerdirectory.PacificSource.com/?nPlan=PSN">http://providerdirectory.PacificSource.com/?nPlan=PSN</a> or call 1-855-274-9814 for a list of network providers.</td>
<td>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.</td>
</tr>
<tr>
<td><strong>Do you need a referral to see a specialist?</strong></td>
<td>No.</td>
<td>You can see the specialist you choose without a referral.</td>
</tr>
</tbody>
</table>
All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>University Health Center (UHC) In-network Provider (You will pay the least)</th>
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<th>Out-of-network Providers (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you visit a health care provider’s office or clinic</strong></td>
<td>Primary care visit to treat an injury or illness</td>
<td>No charge, deductible does not apply</td>
<td>$20 co-pay/visit, deductible does not apply</td>
<td>$35 co-pay/visit, deductible does not apply</td>
<td>Deductible then 50% co-insurance</td>
<td>Preventive Physicals: 13 visits ages 0-36 months, annually ages 3 and older. Well Woman Visits: annually. You may have to pay for services that aren’t preventive. Ask your provider if the services needed are preventive. Then check what you plan will pay for.</td>
</tr>
<tr>
<td>Specialist visit</td>
<td>No charge, deductible does not apply</td>
<td>$30 co-pay/visit, deductible does not apply</td>
<td>$50 co-pay/visit, deductible does not apply</td>
<td>Deductible then 50% co-insurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventive care/screening/screening/immunization</td>
<td>No charge, deductible does not apply</td>
<td>No charge, deductible does not apply</td>
<td>No charge, deductible does not apply</td>
<td>Not covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>No charge, deductible does not apply</td>
<td>10% co-insurance, deductible does not apply</td>
<td>20% co-insurance, deductible does not apply</td>
<td>Deductible then 50% co-insurance</td>
<td>None</td>
</tr>
<tr>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>Not available</td>
<td>$200 co-pay/test, deductible does not apply</td>
<td>$300 co-pay/test + 20% co-insurance, deductible does not apply</td>
<td>Deductible then 50% co-insurance</td>
<td>Preauthorization required.</td>
<td></td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td>Tier one drugs</td>
<td>Preventive: No charge, deductible does not apply Retail: $5 co-pay, deductible does not apply Mail: Not available</td>
<td>Preventive: No charge, deductible does not apply Retail: $15 co-pay, deductible does not apply Mail: $15 co-pay</td>
<td>Preventive: No charge, deductible does not apply Retail: $15 co-pay, deductible does not apply Mail: $15 co-pay</td>
<td>Not covered</td>
<td>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. Preauthorization required for certain drugs.</td>
</tr>
</tbody>
</table>

More information about
<table>
<thead>
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<tr>
<td>prescription drug coverage is available at <a href="http://PacificSource.com/uo">http://PacificSource.com/uo</a>.</td>
<td>Tier two drugs</td>
<td>Retail: $20 co-pay, deductible does not apply Mail: Not available</td>
<td>Retail: $35 co-pay, deductible does not apply Mail: $35 co-pay, deductible does not apply</td>
<td>Retail: $35 co-pay, deductible does not apply Mail: $35 co-pay, deductible does not apply</td>
<td></td>
<td>Specialty: First fill via in-network retail pharmacy or U of O Health Center will be covered. All subsequent fills are required to be at an in-network specialty pharmacy provider. Limited to 30 day supply.</td>
</tr>
<tr>
<td></td>
<td>Tier three drugs</td>
<td>Retail: $40 co-pay, deductible does not apply Mail: Not available</td>
<td>Retail: $60 co-pay, deductible does not apply Mail: $60 co-pay, deductible does not apply</td>
<td>Retail: $60 co-pay, deductible does not apply Mail: $60 co-pay, deductible does not apply</td>
<td></td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Tier four drugs</td>
<td>Deductible then 50% co-insurance Deductible then 50% co-insurance Deductible then 50% co-insurance</td>
<td></td>
<td></td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>Not available</td>
<td>Deductible then 10% co-insurance Deductible then 20% co-insurance Deductible then 50% co-insurance</td>
<td>Deductible then 10% co-insurance Deductible then 20% co-insurance Deductible then 50% co-insurance</td>
<td>Not available</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No charge, deductible does not apply</td>
<td>Deductible then 10% co-insurance Deductible then 20% co-insurance Deductible then 50% co-insurance</td>
<td>Deductible then 10% co-insurance Deductible then 20% co-insurance Deductible then 50% co-insurance</td>
<td>Not available</td>
<td></td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>Not available</td>
<td>Medical Emergency: $300 co-pay, deductible does not apply Non-Emergency: $300 co-pay/visit + 10% co-insurance, deductible does not apply Medical Emergency: $300 co-pay, deductible does not apply Non-Emergency: $300 co-pay/visit + 20% co-insurance, deductible does not apply</td>
<td>Medical Emergency: $300 co-pay, deductible does not apply Non-Emergency: $300 co-pay/visit + 20% co-insurance, deductible does not apply</td>
<td>Co-pay waived if admitted.</td>
<td></td>
</tr>
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</tr>
<tr>
<td>Emergency medical transportation</td>
<td>Ground and Air: Not available</td>
<td>Ground: $300 co-pay/trip + 10% co-insurance, deductible does not apply</td>
<td>Ground and Air: $300 co-pay/trip + 20% co-insurance, deductible does not apply</td>
<td>Ground and Air: Deductible then 50% co-insurance</td>
<td>Limited to nearest facility able to treat condition. Air covered if ground medically or physically inappropriate. Out-of-network air based on 200 percent of Medicare allowance.</td>
<td></td>
</tr>
<tr>
<td>Urgent care</td>
<td>Not available</td>
<td>$30 co-pay/visit, deductible does not apply</td>
<td>$50 co-pay/visit, deductible does not apply</td>
<td>Deductible then 50% co-insurance</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>Not available</td>
<td>Deductible then 10% co-insurance</td>
<td>Deductible then 20% co-insurance</td>
<td>Deductible then 50% co-insurance</td>
<td>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.</td>
</tr>
<tr>
<td>Physician/surgeon fees</td>
<td>Not available</td>
<td>Deductible then 10% co-insurance</td>
<td>Deductible then 20% co-insurance</td>
<td>Deductible then 50% co-insurance</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>No charge, deductible does not apply</td>
<td>$20 co-pay/visit, deductible does not apply</td>
<td>$35 co-pay/visit, deductible does not apply</td>
<td>Deductible then 50% co-insurance</td>
<td>None</td>
</tr>
<tr>
<td>Inpatient services</td>
<td>Not available</td>
<td>Deductible then 10% co-insurance</td>
<td>Deductible then 20% co-insurance</td>
<td>Deductible then 50% co-insurance</td>
<td>Preauthorization required for some inpatient services.</td>
<td></td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>Not available</td>
<td>Deductible then 10% co-insurance</td>
<td>Deductible then 20% co-insurance</td>
<td>Deductible then 50% co-insurance</td>
<td>Cost sharing does not apply to preventive services. Practitioner delivery and hospital visits are covered under prenatal and postnatal care. Facility is covered the same as any other hospital</td>
</tr>
<tr>
<td>Childbirth/delivery professional services</td>
<td>Not available</td>
<td>Deductible then 10% co-insurance</td>
<td>Deductible then 20% co-insurance</td>
<td>Deductible then 50% co-insurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Childbirth/delivery facility services</td>
<td>Not available</td>
<td>Deductible then 10% co-insurance</td>
<td>Deductible then 20% co-insurance</td>
<td>Deductible then 50% co-insurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
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<td>-------------------------------------------------</td>
<td>--------------------------------</td>
<td>-------------------------------------------------</td>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td>Home health care</td>
<td>Not available</td>
<td>Deductible then 10% co-insurance</td>
<td>Deductible then 20% co-insurance</td>
<td>Deductible then 50% co-insurance</td>
<td>No coverage for private duty nursing or custodial care. Preauthorization required.</td>
<td></td>
</tr>
<tr>
<td>Rehabilitation services</td>
<td>Inpatient: Not available</td>
<td>Inpatient: Deductible then 10% co-insurance</td>
<td>Inpatient: Deductible then 20% co-insurance</td>
<td>Inpatient: Deductible then 50% co-insurance</td>
<td>Inpatient: Limited to 30 days/contract year unless medically necessary to treat a mental health diagnosis. Preauthorization required. Outpatient: No coverage for recreation therapy. Limited to a combined maximum of 30 visits/contract year unless medically necessary to treat a mental health diagnosis.</td>
<td></td>
</tr>
<tr>
<td>Habilitation services</td>
<td>Inpatient: Not available</td>
<td>Inpatient: Deductible then 10% co-insurance</td>
<td>Inpatient: Deductible then 20% co-insurance</td>
<td>Inpatient: Deductible then 50% co-insurance</td>
<td>Inpatient: Limited to 30 days/contract year unless medically necessary to treat a mental health diagnosis. Preauthorization required. Outpatient: Limited to a combined maximum of 30 visits/contract year unless medically necessary to treat a mental health diagnosis.</td>
<td></td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td>Not available</td>
<td>Not available</td>
<td>Deductible then 20% co-insurance</td>
<td>Deductible then 50% co-insurance</td>
<td>Limited to 60 days/contract year. No coverage for custodial care.</td>
<td></td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>No charge, deductible does not apply</td>
<td>No charge, deductible does not apply</td>
<td>Deductible then 20% co-insurance</td>
<td>Deductible then 50% co-insurance</td>
<td>Limited to: $5,000/year overall if not an essential health benefit; one pair/year for glasses or contact lenses; one breast pump/pregnancy;</td>
<td></td>
</tr>
</tbody>
</table>
### Common Medical Event

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>University Health Center (UHC) In-network Provider (You will pay the least)</th>
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<th>PSN In-network Provider (You will pay more)</th>
<th>Out-of-network Providers (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospice services</td>
<td>Deductible then 10% co-insurance</td>
<td>Deductible then 20% co-insurance</td>
<td>Deductible then 50% co-insurance</td>
<td>No coverage for private duty nursing.</td>
<td></td>
</tr>
<tr>
<td>Children’s eye exam</td>
<td>No charge, deductible does not apply</td>
<td>No charge, deductible does not apply</td>
<td>No charge, deductible does not apply</td>
<td>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 contacts (lenses and fitting) in lieu of glasses per contract year.</td>
<td></td>
</tr>
<tr>
<td>Children’s glasses</td>
<td>No charge, deductible does not apply</td>
<td>No charge, deductible does not apply</td>
<td>No charge, deductible does not apply</td>
<td>Routine and problem focused dental exams are covered for members through age 18.</td>
<td></td>
</tr>
<tr>
<td>Children’s dental check-up</td>
<td>No charge, deductible does not apply</td>
<td>No charge, deductible does not apply</td>
<td>No charge, deductible does not apply</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 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:

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.

<table>
<thead>
<tr>
<th>Peg is Having a Baby</th>
<th>Managing Joe's type 2 Diabetes</th>
<th>Mia's Simple Fracture</th>
</tr>
</thead>
<tbody>
<tr>
<td>(9 months of in-network pre-natal care and a hospital delivery)</td>
<td>(a year of routine in-network care of a well-controlled condition)</td>
<td>(in-network emergency room visit and follow up care)</td>
</tr>
<tr>
<td><strong>The plan’s overall deductible</strong></td>
<td><strong>The plan’s overall deductible</strong></td>
<td><strong>The plan’s overall deductible</strong></td>
</tr>
<tr>
<td>$300</td>
<td>$300</td>
<td>$300</td>
</tr>
<tr>
<td><strong>Specialist copayment</strong></td>
<td><strong>Specialist copayment</strong></td>
<td><strong>Specialist copayment</strong></td>
</tr>
<tr>
<td>$30</td>
<td>$30</td>
<td>$30</td>
</tr>
<tr>
<td><strong>Hospital (facility) coinsurance</strong></td>
<td><strong>Hospital (facility) coinsurance</strong></td>
<td><strong>Hospital (facility) coinsurance</strong></td>
</tr>
<tr>
<td>10%</td>
<td>10%</td>
<td>10%</td>
</tr>
<tr>
<td><strong>Other coinsurance</strong></td>
<td><strong>Other coinsurance</strong></td>
<td><strong>Other coinsurance</strong></td>
</tr>
<tr>
<td>10%</td>
<td>10%</td>
<td>10%</td>
</tr>
</tbody>
</table>

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 | $300 |
| Copayments | $20 |
| Coinsurance | $1,200 |

What isn’t covered
- Limits or exclusions $60
The total Peg would pay is $1,580

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 | $0 |
| Copayments | $500 |
| Coinsurance | $0 |

What isn’t covered
- Limits or exclusions $60
The total Joe would pay is $560

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 $1,900

In this example, Mia would pay:

| Cost Sharing | |
|-------------| |
| Deductibles | $40 |
| Copayments | $700 |
| Coinsurance | $10 |

What isn’t covered
- Limits or exclusions $60
The total Mia would pay is $750

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