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 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 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) in-network provider: $0 person/ $0 family | UO Exclusive in-network provider and Voyager in-network provider: $300 person/ $900 family | Out-of-network 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; In-network provider ER visits and out-of-network provider ER medical emergency visits. In-network provider: office visits, specialist visits, outpatient rehabilitation services, outpatient habilitation services, advanced diagnostic imaging, diagnostic and therapeutic radiology/lab and dialysis, urgent care, ambulance. Prescription drug coverage: Tier one drugs, Tier two drugs, Tier three 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 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 Center (UHC), UO Exclusive in-network provider, Voyager in-network provider: $5,000 person/ $10,000 family | out-of-network provider: $10,000 person/ $12,700 family	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 limit 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=Voyager or call 1-855-274-9814 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) In-network Provider (You will pay the least)	UO Exclusive In-network Provider (You will pay more)	Voyager 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	$20 co-pay/visit, deductible does not apply	$35 co-pay/visit, deductible does not apply	Deductible then 50% coinsurance	None
	Specialist visit	No charge, deductible does not apply	$30 co-pay/visit, deductible does not apply	$50 co-pay/visit, deductible does not apply	Deductible then 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: 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 you need 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, deductible does not apply	20% coinsurance, deductible does not apply	Deductible then 50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	Not available	$200 co-pay/test, deductible does not apply	$300 co-pay/test + 20% coinsurance, deductible does not apply	Deductible then 50% coinsurance	Preauthorization is required.
If you need drugs to treat your illness or condition	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	Preventive: No charge, deductible does not apply Retail: $15 co-pay, deductible does not apply	Not covered	Retail limited to 30 day supply. Mail limited to 30 day supply. Preauthorization is required for certain drugs.

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) In-network Provider (You will pay the least)	UO Exclusive In-network Provider (You will pay more)	Voyager In-network Provider (You will pay more)	Out-of-network Providers (You will pay the most)	
More information about prescription drug coverage is available at http://PacificSource.com/uo.			Mail: $15 co-pay, deductible does not apply	Mail: $15 co-pay, deductible does not apply		Select medications from the IHC/UCTC available for 90 day supply. Specialty drugs: 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.
	Tier two drugs	Retail: $20 co-pay, deductible does not apply Mail: Not available	Retail: $35 co-pay, deductible does not apply Mail: $35 co-pay, deductible does not apply	Retail: $35 co-pay, deductible does not apply Mail: $35 co-pay, deductible does not apply	Not covered	
	Tier three drugs	Retail: $40 co-pay, deductible does not apply Mail: Not available	Retail: $60 co-pay, deductible does not apply Mail: $60 co-pay, deductible does not apply	Retail: $60 co-pay, deductible does not apply Mail: $60 co-pay, deductible does not apply	Not covered	
	Tier four drugs	Deductible then 50% coinsurance	Deductible then 50% coinsurance	Deductible then 50% coinsurance	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not available	Deductible then 10% coinsurance	Deductible then 20% coinsurance	Deductible then 50% coinsurance	None
	Physician/surgeon fees	No charge, deductible does not apply	Deductible then 10% coinsurance	Deductible then 20% coinsurance	Deductible then 50% coinsurance	
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	Medical Emergency: $300 co-pay/visit, deductible does not apply Non-Emergency: $300 co-pay/visit + 20% coinsurance,	Medical Emergency: $300 co-pay/visit, deductible does not apply Non-Emergency: Deductible then 50% coinsurance	Co-pay waived if admitted.

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) In-network Provider (You will pay the least)	UO Exclusive In-network Provider (You will pay more)	Voyager In-network Provider (You will pay more)	Out-of-network Providers (You will pay the most)	
			not apply	deductible does not apply		
	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: Deductible then 50% coinsurance	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.
	Urgent care	Not available	$30 co-pay/visit, deductible does not apply	$50 co-pay/visit, deductible does not apply	Deductible then 50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	Not available	Deductible then 10% coinsurance	Deductible then 20% coinsurance	Deductible then 50% coinsurance	Limited to semi-private room unless intensive or coronary care units, medically necessary isolation, or hospital only has private rooms. Preauthorization is required for some inpatient services.
	Physician/surgeon fees	Not available	Deductible then 10% coinsurance	Deductible then 20% coinsurance	Deductible then 50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	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 50% coinsurance	None
	Inpatient services	Not available	Deductible then 10% coinsurance	Deductible then 20% coinsurance	Deductible then 50% coinsurance	Preauthorization is required for some inpatient services.
If you are pregnant	Office visits	Not available	Deductible then 10% coinsurance	Deductible then 20% coinsurance	Deductible then 50% coinsurance	Cost sharing does not apply to certain preventive services. Practitioner delivery and hospital visits are covered under prenatal and postnatal care. Facility is
	Childbirth/delivery professional services	Not available	Deductible then 10% coinsurance	Deductible then 20% coinsurance	Deductible then 50% coinsurance	

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) In-network Provider (You will pay the least)	UO Exclusive In-network Provider (You will pay more)	Voyager In-network Provider (You will pay more)	Out-of-network Providers (You will pay the most)	
	Childbirth/delivery facility services	Not available	Deductible then 10% coinsurance	Deductible then 20% coinsurance	Deductible then 50% coinsurance	covered the same as any other hospital services. Coverage includes termination of pregnancy.
If you need help recovering or have other special health needs	Home health care	Not available	Deductible then 10% coinsurance	Deductible then 20% coinsurance	Deductible then 50% coinsurance	No coverage for private duty nursing or custodial care. Preauthorization is required.
	Rehabilitation services	Inpatient: Not available Outpatient: No charge, deductible does not apply	Inpatient: Deductible then 10% coinsurance Outpatient: $20 co-pay/visit, deductible does not apply	Inpatient: Deductible then 20% coinsurance Outpatient: $35 co-pay/visit, deductible does not apply	Inpatient: Deductible then 50% coinsurance Outpatient: Deductible then 50% coinsurance	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.
	Habilitation services	Inpatient: Not available Outpatient: No charge, deductible does not apply	Inpatient: Deductible then 10% coinsurance Outpatient: $20 co-pay/visit, deductible does not apply	Inpatient: Deductible then 20% coinsurance Outpatient: $35 co-pay/visit, deductible does not apply	Inpatient: Deductible then 50% coinsurance Outpatient: Deductible then 50% coinsurance	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.
	Skilled nursing care	Not available	Not available	Deductible then 20% coinsurance	Deductible then 50% coinsurance	Limited to 60 days/contract year. No coverage for custodial care.
	Durable medical equipment	No charge, deductible does not apply			Deductible then 50% coinsurance	Limited to: $5,000/year overall if not an essential health benefit; one

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) In-network Provider (You will pay the least)	UO Exclusive In-network Provider (You will pay more)	Voyager In-network Provider (You will pay more)	Out-of-network Providers (You will pay the most)	
			Deductible then 10% coinsurance	Deductible then 20% coinsurance		pair/year for glasses or contact lenses; one breast pump/pregnancy; one wig/contract year for chemotherapy or radiation therapy. Preauthorization required if equipment is over $1,000 and for power-assisted wheelchairs. 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.
	Hospice services	Not available	Deductible then 10% coinsurance	Deductible then 20% coinsurance	Deductible then 50% coinsurance	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	No charge, deductible does not apply	Deductible then 25% coinsurance	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.
	Children's glasses	Not available	No charge, deductible does not apply	No charge, deductible does not apply	Deductible then 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	• 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 $300
- Specialist copayment $30
- 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	$12,800

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

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 $30
- Hospital (facility) coinsurance 10%
- Other coinsurance 10%

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

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

- The plan's overall deductible $300
- Specialist copayment $30
- Hospital (facility) coinsurance 10%
- Other coinsurance 10%

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	$1,900

In this example, Mia would pay:

Cost sharing	
Deductibles	$40
Copayments	$700
Coinsurance	$10
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$750

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