MEDICAL BENEFIT SUMMARY

Comprehensive Medical Plan
International Students

Contract Year: UO Law Students: 8/10/2021 to 8/9/2022
UO Students (Undergraduate/Non-Law Graduate): 9/15/2021 to 9/14/2022

Who is eligible? University of Oregon Guidelines

Provider Network: UO Exclusive Network and Voyager 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 Contract Year**	**Per Family, Per Contract Year**
University Health Services	None	None
UO Exclusive Network & Voyager Network (In-network Providers)	$300	$900
Out-of-network Providers	$1,000	$3,000
Out-of-Pocket Limit	**Per Person, Per Contract Year**	**Per Family, Per Contract Year**
UHS, UO Exclusive Network, and Voyager 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 can bill you for the difference between the amount charged by the provider and the amount allowed by the Student Plan, 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' 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):	Voyager 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	No deductible, $20 co-pay/visit	No deductible, $35 co-pay/visit	Deductible then 50% co-insurance
Naturopath office visits	Not available	Not available	No deductible, $35 co-pay/visit	Deductible then 50% co-insurance
Specialist office and home visits	No deductible, No charge	No deductible, $30 co-pay/visit	No deductible, $50 co-pay/visit	Deductible then 50% co-insurance
Telemedicine	No deductible, No charge	No deductible, $20 co-pay/visit	No deductible, $35 co-pay/visit	Deductible then 50% co-insurance
Office procedures and supplies	No deductible, No charge	Deductible then 10% co-insurance	Deductible then 20% co-insurance	Deductible then 50% co-insurance
Surgery	No deductible, No charge	Deductible then 10% co-insurance	Deductible then 20% co-insurance	Deductible then 50% co-insurance
Outpatient rehabilitation services	No deductible, No charge	No deductible, $20 co-pay/visit	No deductible, $35 co-pay/visit	Deductible then 50% co-insurance
Outpatient habilitation services	No deductible, No charge	No deductible, $20 co-pay/visit	No deductible, $35 co-pay/visit	Deductible then 50% co-insurance
Hospital Services				
Inpatient room and board	Not available	Deductible then 10% co-insurance	Deductible then 20% co-insurance	Deductible then 50% co-insurance
Inpatient rehabilitation services	Not available	Deductible then 10% co-insurance	Deductible then 20% co-insurance	Deductible then 50% co-insurance
Inpatient habilitation services	Not available	Deductible then 10% co-insurance	Deductible then 20% co-insurance	Deductible then 50% co-insurance
Skilled nursing facility care	Not available	Not available	Deductible then 20% co-insurance	Deductible then 50% co-insurance
Outpatient Services				
Outpatient surgery/services	Not available	Deductible then 10% co-insurance	Deductible then 20% co-insurance	Deductible then 50% co-insurance
Advanced diagnostic imaging	Not available	No deductible, $200 co-pay/test	No deductible, $300 co-pay/test then 20% co-insurance	Deductible then 50% co-insurance

Service	University Health Services:	UO Exclusive Network (In-network Providers):	Voyager Network (In-network Providers):	Out-of-network Providers:
Diagnostic and therapeutic radiology/lab and dialysis	No deductible, No charge	No deductible, 10% co-insurance	No deductible, 20% co-insurance	Deductible then 50% co-insurance
Urgent and Emergency Services				
Urgent care center visits	Not available	No deductible, $30 co-pay/visit	No deductible, $50 co-pay/visit	Deductible then 50% co-insurance
Emergency room visits – medical emergency	Not available	No deductible, $300 co-pay/visit^	No deductible, $300 co-pay/visit^	No deductible, $300 co-pay/visit^
Emergency room visits – non-emergency	Not available	No deductible, $300 co-pay/visit then 10% co-insurance^	No deductible, $300 co-pay/visit then 20% co-insurance^	Deductible then 50% co-insurance
Ambulance, ground	Not available	No deductible, $300 co-pay/trip then 10% co-insurance	No deductible, $300 co-pay/trip then 20% co-insurance	Deductible then 50% co-insurance
Ambulance, air	Not available	Not available	No deductible, $300 co-pay/trip then 20% co-insurance	Deductible then 50% co-insurance+
Maternity Services **				
Physician/Provider services (global charge)	Not available	Deductible then 10% co-insurance	Deductible then 20% co-insurance	Deductible then 50% co-insurance
Hospital/Facility services	Not available	Deductible then 10% co-insurance	Deductible then 20% co-insurance	Deductible then 50% co-insurance
Mental Health and Substance Use Disorder Services*				
Office visits	No deductible, No charge	No deductible, $20 co-pay/visit	No deductible, $35 co-pay/visit	Deductible then 50% co-insurance
Inpatient care	Not available	Deductible then 10% co-insurance	Deductible then 20% co-insurance	Deductible then 50% co-insurance
Residential programs	Not available	Not available	Deductible then 20% co-insurance	Deductible then 50% co-insurance
Other Covered Services				
Allergy injections	Not available	Deductible then 10% co-insurance	Deductible then 20% co-insurance	Deductible then 50% co-insurance
Durable medical equipment	No deductible, No charge	Deductible then 10% co-insurance	Deductible then 20% co-insurance	Deductible then 50% co-insurance
Home health services	Not available	Deductible then 10% co-insurance	Deductible then 20% co-insurance	Deductible then 50% co-insurance
Acupuncture	No deductible, No charge	Not available	No deductible, $35 co-pay/visit	Deductible then 50% co-insurance
Chiropractic manipulation/spinal manipulation	Not available	Not available	No deductible, $35 co-pay/visit	Deductible then 50% co-insurance
Transplants	Not available	Not available	Deductible then 20% co-insurance	Deductible then 50% co-insurance

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

^ Co-pay applies to ER physician and facility charges only. Co-pay 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, co-payment, or co-insurance.

+ Out-of-network air ambulance coverage is covered at 200 percent of the Medicare allowance. You may be held responsible for the amount billed in excess. Contact the PacificSource Customer Service team with questions.

* 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.

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 contract 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 contract 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 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 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.

Preauthorization

Coverage of certain medical services and surgical procedures requires a benefit determination by PacificSource before the services are performed. This process is called ‘preauthorization’. Preauthorization 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. Preauthorization does not change your out-of-pocket expense for in-network and out-of-network providers. You’ll find the most current preauthorization list on our website, PacificSource.com/uo.

PHARMACY BENEFIT SUMMARY

Comprehensive Pharmacy Plan
International Students
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 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 co-payment and/or co-insurance for prescription drugs obtained from an in-network pharmacy are waived during the remainder of the contract 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.

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 Services team or visit PacificSource.com/uo to view the 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, co-payments, and/or co-insurance 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 pharmaceutical is dispensed, you are responsible for the amounts below:

	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, $5 co-pay>	No deductible, $20 co-pay	No deductible, $40 co-pay	Deductible then 50% co-insurance
In-network Retail Pharmacy^*					
Up to a 30 day supply:	No deductible, No charge	No deductible, $15 co-pay	No deductible, $35 co-pay	No deductible, $60 co-pay	Deductible then 50% co-insurance
In-network Mail Order Pharmacy^					
Up to a 30 day supply:	No deductible, No charge	No deductible, $15 co-pay	No deductible, $35 co-pay	No deductible, $60 co-pay	Deductible then 50% co-insurance
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% co-insurance				

^Remember to show your PacificSource ID card each time you fill a prescription at a retail pharmacy. If your ID card is not used, the benefits will be the same as the out-of-network pharmacy benefit.
>Select medications available for a 90 day supply.
***Compounded medications are subject to a preauthorization 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 co-payment and/or co-insurance 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 co-payment and/or co-insurance. The cost difference between the brand name and generic drug does not apply toward the medical plan's out-of-pocket limit. This does not apply to tobacco cessation medications or bowel prep kit medications 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

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, co-payment and/or co-insurance for covered charges apply to the medical plan's out-of-pocket limit.

If charges for a service or supply are less than the amount allowed, the benefit will be equal to the actual charge. If charges for a service or supply are greater than the amount allowed, the expense above the allowed amount is the member's responsibility and will not apply toward the member's medical plan deductible or out-of-pocket limit.

Member Responsibility

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% co-insurance
Vision hardware or Contact Lenses	No deductible, No charge for one pair per year for frames or lenses	Medical Deductible then 25% co-insurance for frames or lenses

Benefit Limitations: enrolled members age 18 and younger

- One routine ophthalmologic exam with refraction, as well as dilation every contract year.
- One pair of glasses (lenses and frames) per contract 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 nonprescription 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.
- Nonprescription lenses.
- Visual analysis that does not include refraction.
- Services or supplies not listed as covered expenses.
- 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 co-payments 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

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 Contract 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% co-insurance	Deductible then 40% co-insurance
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% co-insurance	Deductible then 50% co-insurance
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% co-insurance	Deductible then 30% co-insurance	Deductible then 40% co-insurance
Simple extractions	Deductible then 20% co-insurance	Deductible then 30% co-insurance	Deductible then 40% co-insurance
Periodontal scaling and root planing	Deductible then 20% co-insurance	Deductible then 30% co-insurance	Deductible then 40% co-insurance
Brush biopsies	Deductible then 20% co-insurance	Deductible then 30% co-insurance	Deductible then 40% co-insurance
Crown re-cement	Deductible then 20% co-insurance	Deductible then 30% co-insurance	Deductible then 40% co-insurance
Full mouth debridement	Deductible then 20% co-insurance	Deductible then 30% co-insurance	Deductible then 40% co-insurance
Pulp capping	Deductible then 20% co-insurance	Deductible then 30% co-insurance	Deductible then 40% co-insurance
Pulpotomy	Deductible then 20% co-insurance	Deductible then 30% co-insurance	Deductible then 40% co-insurance
Palliative Care	Deductible then 20% co-insurance	Deductible then 30% co-insurance	Deductible then 40% co-insurance
Anti-Microbial Agents	Deductible then 20% co-insurance	Deductible then 30% co-insurance	Deductible then 40% co-insurance
Diagnostic Casts	Deductible then 20% co-insurance	Deductible then 30% co-insurance	Deductible then 40% co-insurance
Denture relines	Deductible then 20% co-insurance	Deductible then 30% co-insurance	Deductible then 40% co-insurance
Alveoloplasty	Deductible then 20% co-insurance	Deductible then 30% co-insurance	Deductible then 40% co-insurance
Core build-up	Deductible then 20% co-insurance	Deductible then 30% co-insurance	Deductible then 40% co-insurance
Tooth desensitization	Deductible then 20% co-insurance	Deductible then 30% co-insurance	Deductible then 40% co-insurance
Pin retention of fillings	Deductible then 20% co-insurance	Deductible then 30% co-insurance	Deductible then 40% co-insurance
Nitrous Oxide	Not available	Deductible then 30% co-insurance	Deductible then 40% co-insurance
Class III Services (Covered for enrolled individuals age 18 and younger.)			
Crowns	Deductible then, 40% co-insurance	Deductible then 50% co-insurance	Deductible then 50% co-insurance
Root canal therapy	Deductible then, 40% co-insurance	Deductible then 50% co-insurance	Deductible then 50% co-insurance

Complicated oral surgery	Deductible then, 40% co-insurance	Deductible then 50% co-insurance	Deductible then 50% co-insurance
Bridges	Deductible then, 40% co-insurance	Deductible then 50% co-insurance	Deductible then 50% co-insurance
Periodontal surgery	Deductible then, 40% co-insurance	Deductible then 50% co-insurance	Deductible then 50% co-insurance
Implants	Deductible then, 40% co-insurance	Deductible then 50% co-insurance	Deductible then 50% co-insurance
Replacement of existing prosthetic device	Deductible then, 40% co-insurance	Deductible then 50% co-insurance	Deductible then 50% co-insurance
Veneers	Deductible then, 40% co-insurance	Deductible then 50% co-insurance	Deductible then 50% co-insurance
Night guards	Deductible then, 40% co-insurance	Deductible then 50% co-insurance	Deductible then 50% co-insurance
Dentures	Deductible then, 40% co-insurance	Deductible then 50% co-insurance	Deductible then 50% co-insurance
Bone grafting	Not available	Deductible then 50% co-insurance	Deductible then 50% co-insurance
Orthodontia for medically necessary reasons for enrolled individuals age 18 and younger	Not available	Deductible then 50% co-insurance	Deductible then 50% co-insurance

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 contract 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 contract 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.

Predetermination

Coverage of certain dental services and surgical procedures are by review. When a planned dental service exceeds $300, this Student Plan recommends a predetermination to determine if certain services and supplies are covered under this Student Plan, and if you meet the Student Plan’s eligibility requirements. Predeterminations are not a guarantee of payment and do not change your out-of-pocket expense.