



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, go to PacificSource.com/studenthealth/. 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 1-888-977-9299 to request a copy.

| Important Questions | Answers | Why this Matters: |
|---|---|--|
| <u>What is the overall deductible?</u> | In-network provider: \$300 individual Out-of-network provider: \$900 individual | Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. |
| <u>Are there services covered before you meet your deductible?</u> | Yes. <u>Preventive care</u> and other services listed below with ' <u>deductible</u> does not apply'. | This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at Healthcare.gov/coverage/preventive-care-benefits/ . |
| <u>Are there other <u>deductibles</u> for specific services?</u> | No. | You don't have to meet <u>deductibles</u> for specific services. |
| <u>What is the <u>out-of-pocket</u> limit for this <u>plan</u>?</u> | In-network provider: \$3,500 individual Out-of-network provider: \$10,500 individual | The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. |
| <u>What is not included in the <u>out-of-pocket</u> limit?</u> | Premiums, <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover. | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> . |
| <u>Will you pay less if you use a <u>network provider</u>?</u> | Yes. See providerdirectory.PacificSource.com/Commercial/?nPlan=Navigator or call 1-888-977-9299 for a list of <u>network providers</u> . | This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services. |
| <u>Do you need a <u>referral</u> to see a <u>specialist</u>?</u> | No. | You can see the <u>specialist</u> you choose without a <u>referral</u> . |



All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

| What You Will Pay | | | | |
|---|--|--|---|--|
| Common Medical Event | Services You May Need | In-network (You will pay the least) | Out-of-network (You will pay the most) | Limitations, Exceptions, & Other Important Information |
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness | First three visits \$5 <u>co-pay/visit</u> , <u>deductible</u> does not apply. Subsequent visits, \$25 <u>co-pay/visit</u> , <u>deductible</u> does not apply. | 50% <u>co-insurance</u> | First 3 visits per benefit year combined for primary care, mental health, behavioral health, and substance abuse visits. |
| | <u>Specialist</u> visit | \$50 <u>co-pay/visit</u> , <u>deductible</u> does not apply | 50% <u>co-insurance</u> | None |
| | <u>Preventive</u> care/ <u>screening</u> /immunization | No charge, <u>deductible</u> does not apply | 50% <u>co-insurance</u> | 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 <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for. Tobacco cessation: Not covered out-of-network. |
| If you have a test | <u>Diagnostic test</u> (x-ray, blood work) | No charge up to the first \$400, <u>deductible</u> does not apply, then 20% <u>co-insurance</u> | 50% <u>co-insurance</u> | None |
| | Imaging (CT/PET scans, MRIs) | 20% <u>co-insurance</u> | 50% <u>co-insurance</u> | Prior authorization required. If not received, you will be responsible for the expense. |

| What You Will Pay | | | | |
|---|--|--|--|---|
| Common Medical Event | Services You May Need | In-network (You will pay the least) | Out-of-network (You will pay the most) | Limitations, Exceptions, & Other Important Information |
| If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at PacificSource.com/drug-list | Generic drugs - Tier 1 | Retail: \$20 <u>co-pay, deductible</u> does not apply Mail: \$60 <u>co-pay, deductible</u> does not apply | 90% <u>co-insurance, deductible</u> does not apply | For all <u>prescription drug</u> list tiers: Prescription benefit includes certain outpatient drugs as a preventive benefit at no charge when received in-network, <u>deductible</u> does not apply. <u>Cost share</u> amounts shown represent a 30 day supply at retail and a 90 day supply at mail order. Quantity for retail is limited to a 30 day supply. Quantity for mail order is limited to a 90 day supply. Quantity for <u>Specialty drug</u> is limited to 30 day supply. Prior authorization required for certain drugs. If not received, you will be responsible for the expense. |
| | Preferred drugs - Tier 2 | Retail: \$35 <u>co-pay, deductible</u> does not apply Mail: \$105 <u>co-pay, deductible</u> does not apply | 90% <u>co-insurance, deductible</u> does not apply | |
| | Non-preferred drugs - Tier 3 | Retail: \$55 <u>co-pay, deductible</u> does not apply Mail: \$165 <u>co-pay, deductible</u> does not apply | 90% <u>co-insurance, deductible</u> does not apply | |
| | Specialty drugs - Tier 4 | Retail: \$80 <u>co-pay, deductible</u> does not apply Mail: \$240 <u>co-pay, deductible</u> does not apply | 90% <u>co-insurance, deductible</u> does not apply | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 20% <u>co-insurance</u> | 50% <u>co-insurance</u> | Prior authorization required for some surgeries. If not received, you will be responsible for the expense. |
| | Physician/surgeon fees | 20% <u>co-insurance</u> | 50% <u>co-insurance</u> | None |
| If you need immediate medical attention | <u>Emergency room care</u> | Medical emergency: \$200 <u>co-pay/visit, deductible</u> does not apply Non-emergency: \$200 <u>co-pay/visit, deductible</u> does not apply | Medical emergency: \$200 <u>co-pay/visit, deductible</u> does not apply Non-emergency: \$200 <u>co-pay/visit, deductible</u> does not apply | <u>Co-pay</u> waived if admitted. |
| | <u>Emergency medical transportation</u> | Ground: 20% <u>co-insurance</u> Air: 20% <u>co-insurance</u> | Ground: 20% <u>co-insurance</u> Air: 20% <u>co-insurance</u> | Limited to nearest facility able to treat condition. Air covered if ground medically or physically inappropriate. |
| | <u>Urgent care</u> | \$25 <u>co-pay/visit, deductible</u> does not apply | 50% <u>co-insurance</u> | None |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 20% <u>co-insurance</u> | 50% <u>co-insurance</u> | Limited to semi-private room, except when a private room is determined to be necessary. |

| What You Will Pay | | | | |
|--|---|--|---|--|
| Common Medical Event | Services You May Need | In-network (You will pay the least) | Out-of-network (You will pay the most) | Limitations, Exceptions, & Other Important Information |
| If you need mental health, behavioral health, or substance abuse services | | | | Prior authorization required for some inpatient services. If not received, you will be responsible for the expense. |
| | Physician/surgeon fees | 20% <u>co-insurance</u> | 50% <u>co-insurance</u> | None |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | First three visits \$5 <u>co-pay/visit, deductible</u> does not apply. Subsequent visits, \$20 <u>co-pay/visit, deductible</u> does not apply. | \$20 <u>co-pay/visit, deductible</u> does not apply | First 3 visits per benefit year combined for primary care, mental health, behavioral health, and substance abuse visits. |
| | Inpatient services | 20% <u>co-insurance</u> | 20% <u>co-insurance</u> | Prior authorization required for some inpatient services. If not received, you will be responsible for the expense. |
| If you are pregnant | Office visits | 20% <u>co-insurance</u> | 50% <u>co-insurance</u> | <u>Cost sharing does not apply for preventive services.</u> Delivery and hospital visits are covered under prenatal and postnatal care. Facility is covered the same as any other hospital services. |
| | Childbirth/delivery professional services | 20% <u>co-insurance</u> | 50% <u>co-insurance</u> | |
| | Childbirth/delivery facility services | 20% <u>co-insurance</u> | 50% <u>co-insurance</u> | |
| If you need help recovering or have other special health needs | <u>Home health care</u> | 20% <u>co-insurance</u> | 50% <u>co-insurance</u> | No coverage for private duty nursing or custodial care. |
| | <u>Rehabilitation services</u> | Inpatient: 20% <u>co-insurance</u> Outpatient: \$25 <u>co-pay/visit, deductible</u> does not apply | Inpatient: 50% <u>co-insurance</u> Outpatient: 50% <u>co-insurance</u> | Inpatient: Limited to 30 days/year. Outpatient: Limited to 30 visits/year. No coverage for recreation therapy. |
| | <u>Habilitation services</u> | Inpatient: 20% <u>co-insurance</u> Outpatient: \$25 <u>co-pay/visit, deductible</u> does not apply | Inpatient: 50% <u>co-insurance</u> Outpatient: 50% <u>co-insurance</u> | Inpatient: Limited to 30 days/year. Outpatient: Limited to 30 visits/year. No coverage for recreation therapy. |
| | <u>Skilled nursing care</u> | 20% <u>co-insurance</u> | 50% <u>co-insurance</u> | Limited to 60 days/year. No coverage for custodial care. |
| | <u>Durable medical equipment</u> | 20% <u>co-insurance</u> | 50% <u>co-insurance</u> | Limited to: one pair/year for glasses or contact lenses; one breast pump/pregnancy; \$150/year for wig for chemotherapy or radiation therapy. Prior authorization |

| What You Will Pay | | | | |
|--|----------------------------|---|---|---|
| Common Medical Event | Services You May Need | In-network (You will pay the least) | Out-of-network (You will pay the most) | Limitations, Exceptions, & Other Important Information |
| | | | | required if equipment is over \$2,500 and for power-assisted wheelchairs, if not received, you will be responsible for the expense. |
| | <u>Hospice services</u> | 20% <u>co-insurance</u> | 50% <u>co-insurance</u> | No coverage for private duty nursing. Respite care limited to 5 consecutive days and 30 days lifetime. |
| If your child needs dental or eye care | Children's eye exam | No charge, <u>deductible</u> does not apply | No charge up to \$40 maximum, <u>deductible</u> does not apply, then 100% <u>co-insurance</u> | For age 18 or younger, one routine eye exam/year. |
| | Children's glasses | No charge, <u>deductible</u> does not apply | No charge up to \$75 maximum, <u>deductible</u> does not apply, then 100% <u>co-insurance</u> | For age 18 or younger, one pair of glasses (frames and lenses) or contacts (lenses and fitting) per year. |
| | Children's dental check-up | No charge, <u>deductible</u> does not apply | No charge, <u>deductible</u> does not apply | For age 18 or younger, two routine or other diagnostic exam/year. For age 18 or younger, problem focused exams are covered. |

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)
- Dental care (Adult)
- Hearing aids (Adult)
- Infertility treatment
- Long-term care
- Private-duty nursing
- 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, 12 visits/year
- Chiropractic care, 20 visits/year
- Hearing aids (Child)
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Weight loss programs

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Division of Financial Regulation at 1-888-877-4894 or at dfr.oregon.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit Healthcare.gov or call 1-800-318-2596.

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 1-888-977-9299 or the Division of Financial Regulation at 1-888-877-4894 or at dfr.oregon.gov.

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 1-888-977-9299.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-977-9299.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-888-977-9299.

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 <u>plan's</u> <u>overall deductible</u> | \$300 |
| ■ <u>Specialist</u> | \$50 <u>co-payment</u> |
| ■ <u>Hospital (facility)</u> | 20% <u>co-insurance</u> |
| ■ <u>Other</u> | 20% <u>co-insurance</u> |

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:

| <u>Cost Sharing</u> | |
|---------------------|--------|
| <u>Deductibles</u> | \$300 |
| <u>Copayments</u> | \$10 |
| <u>Coinsurance</u> | \$2500 |

What isn't covered

Limits or exclusions **\$60**

The total Peg would pay is **\$2,870**

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

| | |
|---|-------------------------|
| ■ The <u>plan's</u> <u>overall deductible</u> | \$300 |
| ■ <u>Specialist</u> | \$50 <u>co-payment</u> |
| ■ <u>Hospital (facility)</u> | 20% <u>co-insurance</u> |
| ■ <u>Other</u> | 20% <u>co-insurance</u> |

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:

| <u>Cost Sharing</u> | |
|---------------------|-------|
| <u>Deductibles</u> | \$300 |
| <u>Copayments</u> | \$900 |
| <u>Coinsurance</u> | \$100 |

What isn't covered

Limits or exclusions **\$20**

The total Joe would pay is **\$1,320**

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

| | |
|---|-------------------------|
| ■ The <u>plan's</u> <u>overall deductible</u> | \$300 |
| ■ <u>Specialist</u> | \$50 <u>co-payment</u> |
| ■ <u>Hospital (facility)</u> | 20% <u>co-insurance</u> |
| ■ <u>Other</u> | 20% <u>co-insurance</u> |

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 **\$2,800**

In this example, Mia would pay:

| <u>Cost Sharing</u> | |
|---------------------|-------|
| <u>Deductibles</u> | \$300 |
| <u>Copayments</u> | \$500 |
| <u>Coinsurance</u> | \$300 |

What isn't covered

Limits or exclusions **\$0**

The total Mia would pay is **\$1,100**

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