The Summary of Benefits an o era e SB o ument i he you hoose a hea th an The SB sho s you ho you an the an ou share the ost for o ere hea th are ser i es T nformation a out the ost of this an a e the remium i e ro i e se arate y This is on y 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.

m ortant uestions	Ans ers	hy this atters
hat is the o era e u ti e	In-network provider: $300 individual | Out-of-network provider: $900 individual	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay.
Are there ser i es o ere efore you meet your e u ti e	Yes. Preventive care and other services listed below with 'deductible does not apply'.	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 Healthcare.gov/coverage/preventive-care-benefits/.
Are there other e u ti es for s e ifi ser i es	No.	You don't have to meet deductibles for specific services.
hat is the ossary o		

ll **o ayment** and **oinsuran e** costs shown in this chart are after your **e u ti e** has been met, if a **e u ti e** applies.

hat ou i ay				
ommon e i a ent	**Ser i es ou ay ee**	**n net or ou i ay the east**	**ut of net or ou i ay the most**	**imitations e tions ther m ortant nformation**
f you isit a hea th are ro i er s offi e or ini	Primary care visit to treat an in ury or illness	First three visits $5 co-pay/visit, deductible does not apply. Subsequent visits, $25 co-pay/visit, deductible does not apply.	50 co-insurance	First 3 visits per benefit year combined for primary care, mental health, behavioral health, and substance abuse visits.
	Specialist visit	$50 co-pay/visit, deductible does not apply	50 co-insurance	None
	Preventive care/screening/immunj ation	No charge, deductible does not apply	50 co-insurance	Preventive Physicals: 13 visits ages 0-3 months, annually ages 3 and older. Well Woman isits: annually. You may have to pay for services that aren't preventive. sk your provider if the services needed are preventive. Then check what your plan will pay for. Tobacco cessation: Not covered out-of-network.
f you ha e a test	iagnostic test (x-ray, blood work)	No charge up to the first $ 00, deductible does not apply, then 20 co-insurance	50 co-insurance	None
	Imaging (CT/PET scans, ls)	_____	_____	

hat ou i ay				
ommon e i a ent	Ser i es ou ay ee	n net or ou i ay the east	ut of net or ou i ay the most	imitations e tions ther m ortant nformation
f you nee ru s to treat your i ness or on ition ore information about prescription drug coverage is available at PacificSource.com/drug-list	Generic drugs - Tier 1	etail: $20 co-pay, deductible does not apply ail: $ 0 co-pay, deductible does not apply	90 co-insurance, deductible does not apply	For all prescription drug list tiers: Prescription benefit includes certain outpatient drugs as a preventive benefit at no charge when received in-network, deductible does not apply. Cost share amounts shown represent a 30 day supply at retail and a 90 day supply at mail order. uantity for retail is limited to a 30 day supply. uantity for mail order is limited to a 90 day supply. uantity for Specialty drug is limited to 30 day supply. Prior authori ation required for certain drugs. If not received, you will be responsible for the expense.
	Preferred drugs - Tier 2	etail: $35 co-pay, deductible does not apply ail: $105 co-pay, deductible does not apply	90 co-insurance, deductible does not apply	
	Non-preferred drugs - Tier 3	etail: $55 co-pay, deductible does not apply ail: $1 5 co-pay, deductible does not apply	90 co-insurance, deductible does not apply	
	Specialty drugs - Tier	etail: $80 co-pay, deductible does not apply ail: $2 0 co-pay, deductible does not apply	90 co-insurance, deductible does not apply	
f you ha e out atient sur ery	Facility fee (e.g., ambulatory surgery center)	20 co-insurance	50 co-insurance	Prior authori ation required for some surgeries. If not received, you will be responsible for the expense.
	Physician/surgeon fees	20 co-insurance	50 co-insurance	None
f you nee imme iate me i a attention	Emergency room care	edical emergency: $200 co-pay/visit, deductible does not apply Non-emergency: $200 co-pay/visit, deductible does not apply	edical emergency: $200 co-pay/visit, deductible does not apply Non-emergency: $200 co-pay/visit, deductible does not apply	Co-pay waived if admitted.
	Emergency medical transportation	Ground: 20 co-insurance ir: 20 co-insurance	Ground: 20 co-insurance ir: 20 co-insurance	imited to nearest facility able to treat condition. ir covered if ground medically or physically inappropriate.
	rgent care	$25 co-pay/visit, deductible does not apply	50 co-insurance	None
f you ha e a hos ita stay	Facility fee (e.g., hospital room)	20 co-insurance	50 co-insurance	imited to semi-private room, except when a private room is determined to be necessary.

ommon e i a ent	Ser i es ou ay ee	hat ou i ay n net or ou i ay the east	ut of net or ou i ay the most	imitations e tions ther m ortant nformation
f you nee menta hea th eha iora hea th or su stan e a use ser i es				Prior authori ation required for some inpatient services. If not received, you will be responsible for the expense.
	Physician/surgeon fees	20 co-insurance	50 co-insurance	None
	Outpatient services	First three visits $5 co-pay/visit, deductible does not apply. Subsequent visits, $20 co-pay/visit, deductible does not apply.	$20 co-pay/visit, deductible does not apply	First 3 visits per benefit year combined for primary care, mental health, behavioral health, and substance abuse visits.
	Inpatient services	20 co-insurance	20 co-insurance	Prior authori ation required for some inpatient services. If not received, you will be responsible for the expense.
f you are re nant	Office visits	20 co-insurance	50 co-insurance	Cost sharing does not apply for preventive services. elivery 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 co-insurance	50 co-insurance	
	Childbirth/delivery facility services	20 co-insurance	50 co-insurance	
	Home health care	20 co-insurance	50 co-insurance	No coverage for private duty nursing or custodial care.
	ehabilitation services	Inpatient: 20 co-insurance Outpatient: $25 co-pay/visit, deductible does not apply	Inpatient: 50 co-insurance Outpatient: 50 co-insurance	Inpatient: imited to 30 days/year. Outpatient: imited to 30 visits/year. No coverage for recreation therapy.
f you nee he re o erin or ha e other s e ia hea th nee s	Habilitation services	Inpatient: 20 co-insurance Outpatient: $25 co-pay/visit, deductible does not apply	Inpatient: 50 co-insurance Outpatient: 50 co-insurance	Inpatient: imited to 30 days/year. Outpatient: imited to 30 visits/year. No coverage for recreation therapy.
	Skilled nursing care	20 co-insurance	50 co-insurance	imited to 0 days/year. No coverage for custodial care.
	urable medical equipment	20 co-insurance	50 co-insurance	imited to: one pair/year for glasses or contact lenses one breast pump/pregnancy $150/year for wig for chemotherapy or radiation therapy. Prior authori ation

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				required if equipment is over $2,500 and for power-assisted wheelchairs, if not received, you will be responsible for the expense.
	Hospice services	20 co-insurance	50 co-insurance	No coverage for private duty nursing. espite care limited to 5 consecutive days and 30 days lifetime.
f your hi nee s enta or eye are	Children's eye exam	No charge, deductible does not apply	No charge up to $ 0 maximum, deductible does not apply, then 100 In-network co-insurance and 30 days lifetime deductible does and 300 .888 Td(In-netram35d(Nlfor)s)(doco-tacts (lfor)s5d(d	
		_____	_____ _____	
		_____	_____	

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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 1-888-877-4589 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 1-888-877-4589 or at dfr.oregon.gov.

Does this plan provide Minimum Essential Coverage?

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 Available

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.

This is a Simple Baby

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