



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at <https://pacificu.myahpcare.com> or by calling 1-855-856-2383.

Important	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	\$300 Per Covered Person, Per Plan Year for In Network \$550 Per Covered Person, Per Plan Year for Out of Network Does not apply to Preventive Services and Prescription Drugs.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan documents to see when the deductible starts over (usually, but not always, January 1 st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. \$5,000 Individual In Network. \$10,000 Individual Out of Network. \$10,000 Family In Network. N/A Family Out of Network.	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, balance-billed 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 .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a <u>network of providers</u> ?	Yes. For a list of In-Network providers, visit www.cigna.com/hcpdirectory/ or call 800-997-1654.	If you use an In-Network doctor or other health care provider , this plan will pay some or all of the costs of covered services. Be aware, your In-Network doctor or hospital may use an Out-of-Network provider for some services. Plans use the term In-Network, preferred , or participating for providers in their network . See the chart starting on page 2 for how this plan pays different kinds of providers .
Do I need a referral to see a <u>specialist</u> ?	No.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about excluded services .

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- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use In-Network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	20% coinsurance \$25 copay	40% coinsurance	Visit limits may apply
	Specialist visit	20% coinsurance \$25 copay	40% coinsurance	Visit limits may apply
	Other practitioner office visit	20% coinsurance \$25 copay	40% coinsurance	Visit limits may apply.
	Preventive care/ screening/ immunization	0% coinsurance	40% coinsurance	Includes preventive health services specified in the health care reform law or benefits provided as mandated by state law.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	---None---
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	---None---

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**National Guardian Life Insurance Company:
Pacific University Student Health Insurance Plan**

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Policy Number: 2016A4A12

Coverage Period: 05/02/2016-08/12/2017

Coverage for: Student and Dependents | Plan Type: PPO

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at pacificu.myahpcare.com	Generic drugs	\$20 copay (retail) /prescription	100% coinsurance	Retail: 30 day supply
	Preferred brand drugs	\$40 copay (retail) /prescription	100% coinsurance	Retail: 30 day supply
	Brand drugs	\$65 copay (retail) /prescription	100% coinsurance	Retail 30 day Supply
	Specialty drugs	100% coinsurance	100% coinsurance	---None---
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	---None---
	Physician/surgeon fees	20% coinsurance	40% coinsurance	---None---
If you need immediate medical attention	Emergency room services	\$50 copay/visit plus 20% coinsurance	\$50 copay/visit plus 20% coinsurance for Emergency	Non-emergency care is covered at 40% coinsurance after \$50 copay and deductible for Out-of-Network.
	Emergency medical transportation	20% coinsurance	20% coinsurance	---None---
	Urgent care	20% coinsurance	40% coinsurance	---None---

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If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	---None---
	Physician/surgeon fee	Physician: \$25 copay, then 20% coinsurance Surgeon: 20% coinsurance	40% coinsurance	---None---
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% coinsurance after \$25 copay	40% coinsurance	---None---
	Mental/Behavioral health inpatient services	20% coinsurance	40% coinsurance	---None---
	Substance use disorder outpatient services	20% coinsurance after \$25 copay	40% coinsurance	---None---
	Substance use disorder inpatient services	20% coinsurance	40% coinsurance	---None---
If you are pregnant	Prenatal and postnatal care	20% coinsurance after \$25 copay	40% coinsurance	---None---
	Delivery and all inpatient services	20% coinsurance	40% coinsurance	---None---

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Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	---None---
	Rehabilitation services	20% coinsurance	40% coinsurance	Visit limits may apply
	Habilitation services	20% coinsurance	40% coinsurance	Visit limits may apply
	Skilled nursing care	20% coinsurance	40% coinsurance	Limited to 60 days per plan year
	Durable medical equipment	20% coinsurance	20% coinsurance	---None---
	Hospice service	20% coinsurance	40% coinsurance	---None---
If your child needs dental or eye care	Eye exam	Preventive Services: 0% coinsurance All other services: 20% coinsurance	40% coinsurance	Preventive Only. Limited to one exam per plan year
	Glasses	0% coinsurance	40% coinsurance	Limited to one pair per plan year
	Dental check-up	Preventive Services: 0% coinsurance All other services: 20% coinsurance	40% coinsurance	Preventive Only. Limited to one exam per 6 months

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Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric Surgery
- Dental Care (Adult)
- Infertility Treatment
- Long-Term Care
- Routine eye care (Adult)
- Routine Foot Care
- Weight Loss Programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic Care
- Cosmetic Surgery
- Hearing aids for children
- Non-emergency care when traveling outside of the U.S.
- Private Duty Nursing

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Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage 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

For more information on your rights to continue coverage, contact the insurer at 1-855-856-2383. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact 1-855-856-2383 or the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy does provide minimum essential coverage.**

—————*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*—————

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About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** \$7,540
- **Plan pays** \$5,680
- **Patient pays** \$1,860

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$300
Copays	\$20
Coinsurance	\$1,390
Limits or exclusions	\$150
Total	\$1,860

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** \$5,400
- **Plan pays** \$3,730
- **Patient pays** \$1,670

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$300
Copays	\$1,050
Coinsurance	\$240
Limits or exclusions	\$80
Total	\$1,670

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Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

- * **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- * **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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