OSU Graduate Assistant Health Insurance

Provider Network: PSN

Annual Deductible	Per Person, Per Contract Year	Per Family, Per Contract Year
All Providers	$100	$300
Out-of-Pocket Limit	**Per Person, Per Contract Year**	**Per Family, Per Contract Year**
Participating Providers	$1,000	$12,700
Non-participating Providers	$3,000	Not applicable

Please note: Your actual costs for services provided by a non-participating provider may exceed this policy's out-of-pocket limit for non-participating services. In addition, non-participating providers can bill you for the difference between the amount charged by the provider and the amount allowed by the insurance company, and this amount is not counted toward the non-participating out-of-pocket limit.

The member is responsible for the above deductible and the following amounts:

Service	Participating Providers:	Non-participating Providers:
Preventive Care		
Well baby/Well child care	No charge*	Deductible then 30% co-insurance
Routine physicals	No charge*	Deductible then 30% co-insurance
Well woman visits	No charge*	Deductible then 30% co-insurance
Routine mammograms	No charge*	Deductible then 30% co-insurance
Immunizations	No charge*	Deductible then 30% co-insurance
Routine colonoscopy	No charge*	Deductible then 30% co-insurance
Prostate cancer screening	No charge*	Deductible then 30% co-insurance
Professional Services		
Office and home visits	Deductible then 10% co-insurance	Deductible then 30% co-insurance
Naturopath office visits	Deductible then 10% co-insurance	Deductible then 30% co-insurance
Specialist office and home visits	Deductible then 10% co-insurance	Deductible then 30% co-insurance
Telemedicine visits	Deductible then 10% co-insurance	Deductible then 30% co-insurance
Office procedures and supplies	Deductible then 10% co-insurance	Deductible then 30% co-insurance
Surgery	Deductible then 10% co-insurance	Deductible then 30% co-insurance
Outpatient rehabilitation and habilitation services	Deductible then 10% co-insurance	Deductible then 30% co-insurance
Hospital Services		
Inpatient room and board	Deductible then 10% co-insurance	Deductible then 30% co-insurance
Inpatient rehabilitation and habilitation services	Deductible then 10% co-insurance	Deductible then 30% co-insurance
Skilled nursing facility care	Deductible then 10% co-insurance	Deductible then 30% co-insurance
Outpatient Services		
Outpatient surgery/services	Deductible then 10% co-insurance	Deductible then 30% co-insurance
Advanced diagnostic imaging	Deductible then 10% co-insurance	Deductible then 30% co-insurance
Diagnostic and therapeutic radiology/lab and dialysis	Deductible then 10% co-insurance	Deductible then 30% co-insurance
Urgent and Emergency Services		
Urgent care center visits	Deductible then 10% co-insurance	Deductible then 30% co-insurance

Service	Participating Providers:	Non-participating Providers:
Emergency room visits – medical emergency	Deductible then $50 co-pay/visit plus 10% co-insurance^	Deductible then $50 co-pay/visit plus 10% co-insurance^
Emergency room visits – non-emergency	Deductible then $50 co-pay/visit plus 10% co-insurance^	Deductible then $50 co-pay/visit plus 30% co-insurance^
Ambulance, ground	Deductible then 20% co-insurance	Deductible then 20% co-insurance
Ambulance, air	Deductible then 50% co-insurance	Deductible then 50% co-insurance+
Maternity Services**		
Physician/Provider services (global charge)	Deductible then 10% co-insurance	Deductible then 30% co-insurance
Hospital/Facility services	Deductible then 10% co-insurance	Deductible then 30% co-insurance
Mental Health/Chemical Dependency Services		
Office visits	Deductible then 10% co-insurance	Deductible then 30% co-insurance
Inpatient care	Deductible then 10% co-insurance	Deductible then 30% co-insurance
Residential programs	Deductible then 10% co-insurance	Deductible then 30% co-insurance
Other Covered Services		
Allergy injections	Deductible then 10% co-insurance	Deductible then 30% co-insurance
Durable medical equipment	Deductible then 10% co-insurance	Deductible then 30% co-insurance
Home health services	Deductible then 10% co-insurance	Deductible then 30% co-insurance
Chiropractic manipulations and acupuncture	Deductible then 10% co-insurance	Deductible then 30% co-insurance
Transplants	Deductible then No charge	Deductible then 30% co-insurance

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

^ Co-pay waived if admitted into hospital.

* Not subject to annual deductible.

+ Non-participating air ambulance coverage is covered at 200 percent of the Medicare allowance. You may be held responsible for the amount billed in excess. Please see your handbook for additional information or contact our Customer Service team with questions.

** 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.

Additional Information

What is the annual deductible?

Your plan's deductible is the amount of money that you pay first, before your plan starts to pay. You'll see that many services, especially preventive care, are covered by the 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. Deductible expense is applied to the out-of-pocket limit.

Participating provider expense and non-participating provider expense apply together toward your deductible.

What is the out-of-pocket limit?

The out-of-pocket limit is the most you'll pay for covered medical expenses during the plan year. Once the out-of-pocket limit has been met, the plan will pay 100 percent of covered charges for the rest of that 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. Be sure to check your Member Handbook, 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 participating and non-participating providers when it comes to meeting your out-of-pocket limit. Only participating provider expense applies to the participating provider out-of-pocket limit. Only non-participating provider expense applies to the non-participating provider out-of-pocket limit.

Payments to providers

Payment to providers is based on the prevailing or contracted PacificSource fee allowance for covered services. Participating providers accept the fee allowance as payment in full. Non-participating providers are allowed to balance bill any remaining balance that your plan did not cover. Services of non-participating providers could result in out-of-pocket expense in addition to the percentage indicated.

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 plan, and if you meet the plan's eligibility requirements. You'll find the most current preauthorization list on our website, PacificSource.com/member/preauthorization.aspx.

PacificSource HEALTH PLANS

Prescription Drug Benefit Summary
OR 15-25-35 S3 ODL

This PacificSource health plan includes coverage for prescription drugs and certain other pharmaceuticals, subject to the information below. This plan complies with federal health care reform.

The amount you pay for covered prescriptions at participating and non-participating pharmacies applies towards your plan's participating 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 a participating or non-participating pharmacy are waived during the remainder of a calendar year in which you have satisfied the medical out-of-pocket limit.

Each time a covered pharmaceutical is dispensed, you are responsible for the amounts below:

	Tier 1:	Tier 2:	Tier 3:
Participating Retail Pharmacy^			
Up to a 30 day supply:	$15 co-pay*	$25 co-pay*	$35 co-pay*
From the Oregon State University Student Health Center Pharmacy			
Up to a 30 day supply:	$15 co-pay*	$25 co-pay*	$35 co-pay*
Participating Mail Order Pharmacy			
Up to a 30 day supply:	$15 co-pay*	$25 co-pay*	$35 co-pay*
31 – 60 day supply:	$30 co-pay*	$50 co-pay*	$70 co-pay*
61 – 90 day supply:	$45 co-pay*	$75 co-pay*	$105 co-pay*
Non-participating Pharmacy			
30 day max fill, no more than three fills allowed per year:	Same as retail		
Tier 4 Specialty Drugs – Participating Specialty Pharmacy			
Up to a 30 day supply:	$35 co-pay*		
Tier 4 Specialty Drugs – Not filled through Participating Specialty Pharmacy			
30 day max fill, no more than three fills allowed per year:	$35 co-pay*		
Compound Drugs**			
Up to a 30 day supply:	$35 co-pay*		

^ *Remember to show your PacificSource member ID card each time you fill a prescription at a retail pharmacy. If your ID card is not used, your benefits cannot be applied and may result in higher out-of-pocket cost.*

* *Not subject to annual medical deductible.*

** *Compounded medications are subject to a prior authorization process. Compounds are generally covered only when all commercially available formulary products have been exhausted and all the ingredients in the compounded medication are on the applicable formulary.*

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. Does not apply to preventive bowel prep kit medications covered under USPSTF guidelines.

If your physician prescribes a non-formulary contraceptive due to medical necessity it may be subject to preauthorization for coverage at no charge.

See your member handbook for important information about your prescription drug benefit, including which drugs are covered, limitations, and more.

This benefit allows you to receive services from licensed providers for chiropractic manipulation and acupuncture care for medically necessary treatment of illness or injury. The service must be within the scope of the provider's license. Refer to the Medical Benefit Summary for your deductible, co-payment and/or co-insurance information.

Covered Services

- Acupuncture from a licensed provider for medically necessary treatment of illness or injury.
- Chiropractic manipulations from a licensed provider for medically necessary treatment of illness or injury.

The combined benefit for all chiropractic manipulation and acupuncture care is limited to 20 visits per person in any contract year.

Excluded Services

- Any service or supply noted as being excluded or not otherwise covered by the medical plan.
- Homeopathic medicines or homeopathic supplies.
- Massage therapy.

The following shows the vision benefit available under this plan for enrolled members for all covered vision exams, lenses, and frames when performed or prescribed by a licensed ophthalmologist or licensed optometrist. 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	Participating Providers	Non-Participating Providers:
Enrolled Members Age 18 and Younger		
Eye exam	No charge*	No charge* up to $40 maximum then 100% co-insurance
Vision hardware	No charge* for one pair per year for frames and/or lenses	No charge* for one pair per year up to $75 maximum, then 100% co-insurance for frames and/or lenses
Enrolled Members Age 19 and Older		
Eye exam	No charge*	No charge* up to $40 maximum then 100% co-insurance
Vision Hardware		
Single vision lenses	No charge*	No charge* up to $56 maximum then 100% co-insurance
Bifocal lenses	No charge*	No charge* up to $84 maximum then 100% co-insurance
Trifocal lenses	No charge*	No charge* up to $116 maximum then 100% co-insurance
Lenticular lenses	No charge*	No charge* up to $236 maximum then 100% co-insurance
Progressive lenses	No charge* up to $116 maximum then 100% co-insurance	
Frames	No charge* up to $75 maximum then 100% co-insurance	
Contact Lenses (in lieu of glasses)		
Contact lenses (in lieu of glasses)	No charge* up to $131 maximum then 100% co-insurance	

* Not subject to annual medical deductible.

Benefit Limitations: enrolled members age 18 and younger

- One vision exam every contract year.
- One pair of glasses (frames and lenses) or contact lenses in lieu of glasses per contract year.

Benefit Limitations: enrolled members age 19 and older

- One vision exam every contract year.
- Lenses: One pair every contract year.
- Frames: Once every contract year.
- Contact lenses: Once every contract year.
- Elective contact lenses are in lieu of frames and lenses.
- Anti-reflective coatings and scratch resistant coatings are covered.

Exclusions

- Special procedures such as orthoptics or vision training.
- Special supplies such as sunglasses (plain or prescription) and subnormal vision aids.
- Polycarbonate lenses for enrolled members age 19 and older.
- 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 workers' 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 your vision benefits

Your PacificSource group health plan includes coverage for vision services. To make the most of those benefits, it's important to keep in mind the following:

Participating Providers

PacificSource is able to add value to your vision benefits by contracting with a network of vision providers. Those providers offer vision services at discounted rates, which are passed on to you in your benefits.

Paying for Services

Please remember to show your current PacificSource member ID card whenever you use your plan's benefits. Our provider contracts require participating providers to bill us directly whenever you receive covered services and supplies. Providers will verify your vision benefits. Participating providers should not ask you to pay the full cost in advance. They may only collect your share of the expense up front, such as co-payments and amounts over your plan's allowances. If you are asked to pay the entire amount in advance, tell the provider you understand they have a contract with PacificSource and they should bill PacificSource directly.

Sales and Special Promotions (sales and promotions are not considered insurance)

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 participating providers already discount their services through their contract with PacificSource, your plan's participating provider benefits cannot be combined with any other discounts or coupons. You can use your plan's participating provider benefits, or you can use your plan's non-participating provider benefits to take advantage of a sale or coupon offer.

If you do take advantage of a special offer, the participating provider may treat you as an uninsured customer and require full payment in advance. You can then send the claim to PacificSource yourself, and we will reimburse you according to your plan's non-participating provider benefits.

PacificSource HEALTH PLANS

Dental Benefit Summary
Dental Choice Plus 0-20-50 50-2500 S3

OSU Graduate Assistant Health Insurance

This dental care policy 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 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).

Advantage Network dentists contract with PacificSource to furnish dental services and supplies for a set fee. That fee is called the contracted allowable fee. Participating providers agree not to collect more than the contracted allowable fee.

Annual Deductible	Per Person, Per Contract Year	Per Family, Per Contract Year
All Providers	$50	$150
Annual Benefit Maximum		
$2,500 per person per contract year. Applies to all covered services.		

The member is responsible for any amounts shown above, in addition to the following amounts.

Service	All Providers
Class I Services	
Examinations	No charge*
Bitewing films, full mouth x-rays, cone beam x-rays, and/or panorex	No charge*
Dental cleaning (prophylaxis and periodontal maintenance)	No charge*
Topical fluoride	No charge*
Fluoride varnish	No charge*
Sealants	No charge*
Space maintainers	No charge*
Athletic mouth guards	No charge*
Brush biopsies	No charge*
Class II Services	
Fillings	Deductible then 20% co-insurance
Simple extractions	Deductible then 20% co-insurance
Periodontal scaling and root planing	Deductible then 20% co-insurance
Full mouth debridement	Deductible then 20% co-insurance
Complicated oral surgery	Deductible then 20% co-insurance
Pulp capping	Deductible then 20% co-insurance
Pulpotomy	Deductible then 20% co-insurance
Root canal therapy	Deductible then 20% co-insurance
Periodontal surgery	Deductible then 20% co-insurance
Tooth desensitization	Deductible then 20% co-insurance
Class III Services	
Crowns	Deductible then 50% co-insurance

Service	All Providers
Replacement of existing prosthetic device	Deductible then 50% co-insurance
Dentures	Deductible then 50% co-insurance
Bridges	Deductible then 50% co-insurance

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

* Not subject to annual deductible.

Additional Information

What is the annual deductible?

Your plan's deductible is the amount of money that you pay first, before your plan starts to pay. You'll see that some services are covered by the 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.

Deductible does not apply to Class I Services.

What is the annual benefit maximum?

The annual benefit maximum is the maximum amount payable by this policy for covered services received each contract year.

Preauthorization.

Coverage of certain dental 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 plan, and if you meet the plan's eligibility requirements. You'll find the most current preauthorization list on our website, PacificSource.com/member/preauthorization.aspx.