

SUMMARY OF BENEFITS



**PREFERRED
7500+30/70% ID0608**

MAXIMUM LIFETIME BENEFIT\$1,000,000

ANNUAL DEDUCTIBLE\$7,500 per person / \$22,500 per family

The deductible is an amount of covered medical expenses the member pays each calendar year before the plan's benefits begin. The deductible applies to all services and supplies except those marked with an asterisk (*).

OUT-OF-POCKET LIMIT

Participating Providers\$4,000 per person / \$8,000 per family per calendar year

Nonparticipating Providers\$5,000 per person / \$15,000 per family per calendar year

The medical out-of-pocket limit for participating providers accumulates separately from the medical out-of-pocket limit for nonparticipating providers. Once the participating provider out-of-pocket limit has been met, this plan will pay 100% of covered charges for participating and network not available providers for the rest of that calendar year. Once the nonparticipating provider out-of-pocket limit has been met, this plan will pay 100% of covered charges for all providers for the rest of that calendar year. Benefits paid in full, deductible, copays, and nonparticipating provider charges in excess of the PacificSource fee allowance do not accumulate toward the out-of-pocket limit.

SERVICE:	COPAY:	PARTICIPATING PROVIDER/ NETWORK NOT AVAILABLE BENEFIT AFTER COPAY:	NONPARTICIPATING PROVIDER BENEFIT AFTER COPAY:
PREVENTIVE CARE (Combined \$500 maximum per calendar year unless otherwise noted)			
* ^ Well Baby Care	\$30 per visit	100%	Not covered
* Routine Physicals	\$30 per visit	100%	Not covered
* Routine Gynecological Exams	\$30 per visit	100%	70%
* ^ Routine Mammogram		100%	70%
* Eye Exam	\$30 per visit	100%	Not covered
* ^ Immunizations		100%	Not covered
^ Routine Colonoscopy		70%	50%
PROFESSIONAL SERVICES			
* Office and Home Visits	\$30 per visit	100%	70%
* Chiropractic/Naturopathic/Acupuncture	\$30 per visit	100%	Not covered
* Urgent Care Center Visits	\$30 per visit	100%	70%
Surgery		70%	50%
Physical/Occupational/Speech Therapy		70%	Not covered
HOSPITAL SERVICES			
Inpatient Room and Board		70%	50%
Inpatient Rehabilitative Care		70%	Not covered
Skilled Nursing Facility Care		70%	50%
OUTPATIENT SERVICES			
Outpatient Surgery		70%	50%
Diagnostic and Therapeutic Radiology and Lab		100% of first \$400*, then 70%	50%
CT/PET Scans, CATH Labs and MRIs		70%	50%
• Emergency Room Visits	\$100 per visit	70%	50%
MENTAL HEALTH/CHEMICAL DEPENDENCY SERVICES			
* Office Visits	\$30 per visit	100%	Not covered
Inpatient Care		70%	Not covered
OTHER COVERED SERVICES			
* Allergy Injections	\$5 per visit	100%	70%
Ambulance, Ground		70%	70%
Ambulance, Air		70%	70%
Durable Medical Equipment		70%	50%
Hospice		70%	Not covered
Home Health Care		70%	50%
• In true medical emergencies, nonparticipating providers are paid at the participating provider level.			
* Not subject to annual deductible.			
^ Not subject to \$500 per calendar year maximum for preventive care services.			

Payment to providers is based on the prevailing or contracted PacificSource fee allowance for covered services. Although participating providers accept the fee allowance as payment in full, nonparticipating providers may not. Services of nonparticipating providers could result in out-of-pocket expense in addition to the percentage indicated. Network Not Available payment is allowed when PacificSource has not contracted with providers in the geographical area of the member's residence or work for a specific service or supply. Payment for Network Not Available is based on the usual, customary, and reasonable charge for the geographical area in which the charge is incurred. For more information, refer to the Payment to Providers section in the member benefit handbook.

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

PacificSource Plan Limitations

GENERAL BENEFIT LIMITATIONS (see handbook for a more complete list and details)

- **Ambulance** benefits are provided for emergency ground ambulance service to the nearest facility able to treat the condition and up to \$6,000 per calendar year for air (only when ground transportation is medically or physically inappropriate).
- **Biofeedback** to treat migraine headaches or urinary incontinence is limited to a lifetime maximum of 10 sessions.
- **Cardiac rehabilitation** for Phase I covered under inpatient hospital, Phase II covered as outpatient hospital benefits up to a lifetime maximum benefit of 36 sessions if preauthorized by PacificSource, and Phase III is not covered.
- **Chiropractic, naturopathic and acupuncture** services and supplies are limited to a combined \$900 per calendar year.
- **Diabetic self-management education** is covered at the time of diagnosis, and up to three hours of education per year if there is significant change in condition or treatment.
- **Durable medical equipment (DME)** prescribed exclusively to treat medical conditions up to an annual maximum of \$5,000. DME over \$500 requires preauthorization. Lenses to correct vision defect resulting from severe medical problem or eye surgery other than refraction procedures has a \$200 max. Breast pump rental or purchase is limited to a lifetime maximum benefit of \$200.
- **Growth hormone** injections or treatments are limited to \$25,000 per calendar year.
- **Home Health Services** are limited to \$5,000 per calendar year when preauthorized by PacificSource.
- **Injury of the jaw or natural teeth** – services must be provided within 18 months of the injury.
- **Inpatient rehabilitation** is covered up to a \$150,000 lifetime maximum.
- **Mental health / chemical dependency** treatment is subject to review for medical necessity and/or appropriateness. Benefits for treatment for mental health, chemical dependency, or dual diagnosis conditions are limited to the following maximums per calendar year:
 - **Inpatient** – 8 days
 - **Outpatient** – 20 visits
- **Organ Transplants:**
 - Maximum lifetime benefit of \$250,000 per person.
 - Travel/housing expenses for recipient and one caregiver is limited to \$5,000.
 - Travel/living expenses are not covered for the recipient's family/donor.
 - If the transplant is performed at a participating transplant facility, covered charges of the facility are subject to plan deductibles, maximum transplant benefit and the lifetime maximum benefit; coinsurance and copayment amounts after deductible are waived.
 - If transplant services are available through a contracted transplant facility but are performed at a noncontracted facility, the plan pays either 60% of the billed amount or \$100,000, whichever is less and are otherwise subject to plan deductibles, copayments, coinsurance, out-of-pocket, maximum transplant benefit and lifetime maximum provisions of the plan.
- **Outpatient pulmonary rehabilitation** is limited to a lifetime maximum of \$1,000.
- **Physical, occupational and speech therapy** services are limited to a combined \$2,000 per calendar year.
- **Preventive Care Services:**
 - **Routine eye exam** is limited to one eye exam per calendar year and is subject to the combined \$500 preventive care maximum benefit.
 - **Routine Physicals, gynecological and eye exams** are limited to a combined \$500 max per calendar year.
 - **Tobacco cessation program** services are covered 100% when provided by a PacificSource approved program. Coverage is limited to a maximum lifetime benefit of two quit attempts.
 - **Well Baby Care** is limited to nine examinations during the first 24 months of life, including a standard in-hospital exam at birth and any appropriate lab services.
- **Pulmonary rehabilitation** is covered for severe chronic lung disease up to a \$1,000 lifetime max if preauthorized.
- **Sleep apnea and other sleeping disorders** require preauthorization. Coverage for oral devices has a \$500 lifetime maximum benefit.
- **Skilled nursing facility** is covered for up to 60 days per calendar year when preauthorized by PacificSource.

GENERAL EXCLUDED SERVICES (see handbook for a more complete list and details)

- Day care or custodial care including help with daily activities such as walking, getting in or out of bed, bathing, dressing, eating, and preparing meals.
- Dental examinations and treatment to prevent, diagnose, or treat diseases of the teeth, tissues, or structures.
- Drugs, homeopathic medicines, or homeopathic supplies furnished by an alternative care provider.
- Family planning services and supplies other than sterilization
- Fitness or exercise programs and health or fitness club memberships
- Foot care (routine), unless you are being treated for diabetes mellitus.
- Immunizations for the purpose of travel, occupation, or foreign residence.
- Infertility, sterility, impotency, frigidity, sexual dysfunction, or sexual transformation diagnosis or treatment
- Obesity or weight control treatment or surgery, even if there are other medical reasons for you to control your weight.
- Orthognathic procedures and over the counter medications.
- Prescription drugs (except as covered under prescription drug card) and over the counter medications.
- Private duty nursing service
- TMJ services or treatment for associated myofascial pain, including physical or oromyofascial therapy.
- Treatment of any condition caused by a war, armed invasion, or act of aggression, or while serving in the armed forces.

This is only a brief list of limitations and exclusions. Please refer to the additional information provided for further explanation of benefits including additional limitations and exclusions.