SUMMARY OF BENEFITS

PacificSource HEALTH PLANS

PREFERRED 1000+20/80% ID0711

MAXIMUM LIFETIME BENEFIT .....No Overall Lifetime Limit
ANNUAL BENEFIT MAXIMUM $2,000,000
ANNUAL DEDUCTIBLE .....$1,000 per person / $3,000 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.....$2,000 per person / $4,000 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			
*	Well Baby Care		100%	10%
*	Routine Physicals		100%	10%
*	Routine Gynecological Exams		100%	80%
*	Routine Mammogram		100%	80%
*	Eye Exam		100%	10%
*	Immunizations		100%	10%
	Routine Colonoscopy		100%*	60%
	PROFESSIONAL SERVICES			
*	Office and Home Visits	$20 per visit	100%	80%
*	Chiropractic/Acupuncture	$20 per visit	100%	10%
*	Urgent Care Center Visits	$20 per visit	100%	80%
	Surgery		80%	60%
	Physical/Occupational/Speech Therapy		80%	10%
	HOSPITAL SERVICES			
	Inpatient Room and Board		80%	60%
	Inpatient Rehabilitative Care		80%	10%
	Skilled Nursing Facility Care		80%	60%
	OUTPATIENT SERVICES			
	Outpatient Surgery		80%	60%
	Diagnostic and Therapeutic Radiology and Lab, and Advanced Imaging		100% of first $400*, then 80%	60%
•	Emergency Room Visits	$100 per visit	80%	60%
	MENTAL HEALTH/CHEMICAL DEPENDENCY SERVICES			
*	Office Visits	$20 per visit	100%	10%
	Inpatient Care		80%	10%
	OTHER COVERED SERVICES			
*	Allergy Injections	$5 per visit	100%	80%
	Ambulance, Ground		80%	80%
	Ambulance, Air		80%	80%
	Durable Medical Equipment		80%	60%
	Hospice		80%	10%
	Home Health Care		80%	60%

- ***In true medical emergencies, nonparticipating providers are paid at the participating provider level.***
- **** Not subject to annual deductible.***

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.