

SUMMARY OF BENEFITS



**PREFERRED
50+5000 ID0112**

MAXIMUM LIFETIME BENEFIT No Overall Lifetime Limit

ANNUAL BENEFIT MAXIMUM \$2,000,000

ANNUAL DEDUCTIBLE \$5,000 per person / \$15,000 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 \$3,500 per person / \$7,000 per family per calendar year

Nonparticipating Providers \$7,000 per person / \$14,000 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, 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%	40%
* Routine Mammogram		100%	40%
* Immunizations		100%	10%
Routine Colonoscopy		100%*	40%
PROFESSIONAL SERVICES			
Office and Home Visits		50%♦	40%
* Chiropractic/Acupuncture		50%	10%
Urgent Care Center Visits		50%♦	40%
Surgery		50%	40%
Physical/Occupational/Speech Therapy		50%	10%
HOSPITAL SERVICES			
Inpatient Room and Board		50%	40%
Inpatient Rehabilitative Care		50%	10%
Skilled Nursing Facility Care		50%	40%
OUTPATIENT SERVICES			
Outpatient Surgery		50%	40%
Diagnostic and Therapeutic Radiology and Lab, and Advanced Imaging		50%	40%
• Emergency Room Visits	\$100 per visit	50%	40%
MENTAL HEALTH/CHEMICAL DEPENDENCY SERVICES			
Office Visits		50%	10%
Inpatient Care		50%	10%
OTHER COVERED SERVICES			
Allergy Injections		50%	40%
Ambulance, Ground/Air		50%	50%
Durable Medical Equipment		50%	40%
Hospice		50%	10%
Home Health Care		50%	40%

♦ **In true medical emergencies, nonparticipating providers are paid at the participating provider level.**

* **Not subject to deductible.**

♦ **First four combined office visits are not subject to deductible and paid at 100% after \$30 copay per visit.**

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.