

# SUMMARY OF BENEFITS



**PREFERRED  
70+500 ID0711**

**MAXIMUM LIFETIME BENEFIT** ..... No Overall Lifetime Limit

**ANNUAL BENEFIT MAXIMUM**..... \$2,000,000

**ANNUAL DEDUCTIBLE**..... \$500 per person / \$1,500 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 ..... \$3,000 per person / \$6,000 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.

<b>SERVICE:</b>	<b>PARTICIPATING PROVIDER/ NETWORK NOT AVAILABLE BENEFIT:</b>	<b>NONPARTICIPATING PROVIDER BENEFIT:</b>
<b>PREVENTIVE CARE</b>		
* Well Baby Care	100%	10%
* Routine Physicals	100%	10%
* Routine Gynecological Exams	100%	50%
* Routine Mammogram	100%	50%
* Eye Exam	100%	10%
* Immunizations	100%	10%
Routine Colonoscopy	100%*	50%
<b>PROFESSIONAL SERVICES</b>		
Office and Home Visits	70%	50%
Chiropractic/Acupuncture	70%	10%
Urgent Care Center Visits	70%	50%
Surgery	70%	50%
Physical/Occupational/Speech Therapy	70%	10%
<b>HOSPITAL SERVICES</b>		
Inpatient Room and Board	70%	50%
Inpatient Rehabilitative Care	70%	10%
Skilled Nursing Facility Care	70%	50%
<b>OUTPATIENT SERVICES</b>		
Outpatient Surgery	70%	50%
Diagnostic and Therapeutic Radiology and Lab, and Advanced Imaging	70%	50%
• Emergency Room Visits	70%	50%
<b>MENTAL HEALTH/CHEMICAL DEPENDENCY SERVICES</b>		
Office Visits	70%	10%
Inpatient Care	70%	10%
<b>OTHER COVERED SERVICES</b>		
Allergy Injections	70%	50%
Ambulance	70%	70%
Durable Medical Equipment	70%	50%
Hospice	70%	10%
Home Health Care	70%	50%
• <b><i>In true medical emergencies, nonparticipating providers are paid at the participating provider level.</i></b>		
* <b><i>Not subject to annual deductible.</i></b>		

*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.***