

# SUMMARY OF BENEFITS



**PREFERRED  
2000+50 0711**

**MAXIMUM LIFETIME BENEFIT** .....No Overall Lifetime Limit  
**ANNUAL DEDUCTIBLE** .....\$2,000 per person / \$4,000 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 a bullet (•). Once a member has paid a total amount toward covered expenses during the calendar year equal to the per person amount listed above, the deductible will be satisfied for that person for the rest of that calendar year. Once any covered family members have paid a combined total toward covered expenses during the calendar year equal to the per family amount listed above, the deductible will be satisfied for all covered family members for the rest of that calendar year. Deductible expense is not applied to the out-of-pocket limit.

**OUT-OF-POCKET LIMIT**

Participating Providers.....\$4,000 per person / \$8,000 per family per calendar year  
 Nonparticipating Providers .....\$5,000 per person per calendar year

Only participating provider expense applies to the participating provider out-of-pocket limit and only nonparticipating provider expense applies to the nonparticipating out-of-pocket limit. Once the participating provider out-of-pocket limit has been met, this plan will pay 100% of covered charges (after the copayment is deducted) 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 (after the copayment is deducted) for nonparticipating providers for the rest of that calendar year. Deductibles, copayments, benefits paid in full and nonparticipating provider charges in excess of the PacificSource allowable fee do not accumulate toward the out-of-pocket limit. Copayments and nonparticipating provider charges in excess of the PacificSource allowable fee will continue to be the member's responsibility even after the out-of-pocket limit is met.

| <b>SERVICE:</b>                                   | <b>PARTICIPATING PROVIDER/<br/>NETWORK NOT AVAILABLE<br/>BENEFIT:</b> | <b>NONPARTICIPATING<br/>PROVIDER BENEFIT:</b> |
|---|---|---|
| <b>PREVENTIVE CARE</b>                            |   |   |
| Well Baby Care                                    | 100%•   | 80%•  |
| Routine Physicals                                 | 100%•   | 80%•  |
| Routine Gynecological Exams                       | 100%•   | 80%•  |
| Immunizations                                     | 100%•   | 80%•  |
| Routine Colonoscopy, Ages 50-75                   | 100%•   | 60%   |
| <b>PROFESSIONAL SERVICES</b>                      |   |   |
| Office and Home Visits                            | 100% after \$50 copay•  | 80% after \$50 copay•                         |
| Office Procedures and Supplies                    | 100%•   | 80%•  |
| Urgent Care Center Visits                         | 100% after \$50 copay•  | 80% after \$50 copay•                         |
| Surgery   | 80%   | 60%   |
| Physical/Occupational/Speech Therapy              | 80%   | 80%   |
| <b>HOSPITAL SERVICES</b>                          |   |   |
| Inpatient Room and Board                          | 80%   | 60%   |
| Inpatient Rehabilitative Care                     | 80%   | 60%   |
| Skilled Nursing Facility Care                     | 80%   | 60%   |
| <b>OUTPATIENT SERVICES</b>                        |   |   |
| Outpatient Surgery/Services                       | 80%   | 60%   |
| Advanced Imaging                                  | 80%   | 60%   |
| Diagnostic and Therapeutic Radiology and Lab      | 80%•  | 60%•  |
| * Emergency Room Visits                           | 80% after \$100 copay•  | 60% after \$100 copay•                        |
| <b>MENTAL HEALTH/CHEMICAL DEPENDENCY SERVICES</b> |   |   |
| Office Visits                                     | 100% after \$50 copay•  | 80% after \$50 copay•                         |
| Inpatient Care                                    | 80%   | 60%   |
| Residential Programs                              | 80%   | 60%   |
| <b>OTHER COVERED SERVICES</b>                     |   |   |
| Allergy Injections                                | 100% after \$5 copay•   | 80% after \$5 copay•                          |
| Ambulance, Ground                                 | 80%   | 80%   |
| Ambulance, Air                                    | 50%   | 50%   |
| Durable Medical Equipment                         | 80%   | 50%   |
| Home Health Care                                  | 80%   | 50%   |

- \* **Copay waived if admitted into hospital. 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 to providers for Network Not Available is based on the usual, customary, and reasonable charge (see "allowable fee" in the Definitions section) for the geographical area in which the charge is incurred.

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