SUMMARY OF BENEFITS

CHOICE 25/200D 0711

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

ANNUAL DEDUCTIBLE..................................... None

OUT-OF-POCKET LIMIT.................................... $2,000 per person / $6,000 per family per calendar year
Once the out-of-pocket limit is reached, payment to participating providers increases to 100% (after the copayment is deducted) for the remainder of the calendar year. Nonparticipating providers continue to be paid at the percentage stated below. Copayment amounts, benefits paid in full and 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.

PRIMARY CARE PRACTITIONER .... All enrolled members must select a primary care practitioner (PCP) from the plan's provider directory to be responsible for their continuing medical care. Referrals are not needed for specialist care.

	SERVICE:	*PARTICIPATING PCP BENEFIT:*	*OTHER PARTICIPATING PROVIDER BENEFIT:*	*NONPARTICIPATING PROVIDER BENEFIT:*
	PREVENTIVE CARE			
	Well Baby Care	100%	100%	50%
	Routine Physicals	100%	100%	50%
	Routine Gynecological Exams	100%	100%	50%
	Immunizations	100%	100%	50%
	Routine Colonoscopy, ages 50-75	100%	100%	50%
	PROFESSIONAL SERVICES			
	Office and Home Visits	100% after $25 copay	100% after $35 copay	50% after $35 copay
	Office Procedures and Supplies	100%	100%	50%
	Urgent Care Center Visits	100% after $25 copay	100% after $35 copay	50% after $35 copay
	Surgery	100% after $50 copay	100% after $50 copay	50% after $50 copay
	Physical/Occupational/Speech Therapy	100% after $25 copay	100% after $35 copay	50% after $35 copay
	HOSPITAL SERVICES			
>	Inpatient Room and Board	100% after $200 per day	100% after $200 per day	50% after $200 per day
	Inpatient Rehabilitative Care	80%	80%	50%
	Skilled Nursing Facility Care	80%	80%	50%
	OUTPATIENT SERVICES			
	Outpatient Surgery/Services	100% after $100 copay	100% after $100 copay	50% after $100 copay
	Advanced Imaging (per procedure)	100% after $100 copay	100% after $100 copay	50% after $100 copay
	Diagnostic & Therapeutic Radiology/Lab	100%	100%	50%
*	Emergency Room Visits	100% after $100 copay	100% after $100 copay	50% after $100 copay
	MENTAL HEALTH/CHEMICAL DEPENDENCY SERVICES			
	Office Visits	100% after $25 copay	100% after $35 copay	50% after $35 copay
>	Inpatient Care	100% after $200 per day	100% after $200 per day	50% after $200 per day
>	Residential Programs	100% after $200 per day	100% after $200 per day	50% after $200 per day
	OTHER COVERED SERVICES			
	Allergy Injections	100% after $5 copay	100% after $5 copay	50% after $5 copay
	Ambulance, Ground	80%	80%	80%
	Ambulance, Air	50%	50%	50%
	Durable Medical Equipment	80%	80%	50%
	Home Health Care	80%	80%	50%

* ***Copay waived if admitted into hospital. In true medical emergencies, nonparticipating providers are paid at the participating provider level.***

> ***Copay subject to 5-day maximum.***

Payment to providers is based on the prevailing or contracted PacificSource allowable fee 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.

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.