

# SUMMARY OF BENEFITS



**PRIME**  
**25/200D 0711**

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

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

**OUT-OF-POCKET LIMIT** ..... \$2,000 per person / \$4,000 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, deductibles, benefits paid in full and charges in excess of the PacificSource allowable fee for services of nonparticipating providers 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. The PCP will coordinate use of healthcare resources to best meet the member's healthcare needs.

<b>SERVICE:</b>	<b>PCP OR REFERRED BENEFIT:</b>	<b>NONPARTICIPATING OR NONREFERRED PROVIDER BENEFIT:</b>
<b>PREVENTIVE CARE</b>		
Well Baby Care	100%	50%
Routine Physicals	100%	50%
Routine Gynecological Exams	100%	50%
Immunizations	100%	50%
Routine Colonoscopy, ages 50-75	100%	50%
<b>PROFESSIONAL SERVICES</b>		
Office and Home Visits	100% after \$25 copay	50% after \$25 copay
Office Procedures and Supplies	100%	50%
Urgent Care Center Visits	100% after \$25 copay	50% after \$25 copay
Surgery	100% after \$50 copay	50% after \$50 copay
Physical / Occupational / Speech Therapy	100% after \$25 copay	50% after \$25 copay
<b>HOSPITAL SERVICES</b>		
>> Inpatient Room and Board	100% after \$200 copay	50% after \$200 copay
>> Inpatient Rehabilitative Care	100% after \$200 copay	50% after \$200 copay
>> Skilled Nursing Facility Care	100% after \$200 copay	50% after \$200 copay
<b>OUTPATIENT SERVICES</b>		
Outpatient Surgery/Services	100% after \$100 copay	50% after \$100 copay
Advanced Imaging	100% after \$100 per procedure	50% after \$100 per procedure
Diagnostic and Therapeutic Radiology and Lab	100%	50%
* Emergency Room Visits	100% after \$100 copay	50% after \$100 copay
<b>MENTAL HEALTH/CHEMICAL DEPENDENCY SERVICES</b>		
^ Office Visits	100% after \$25 copay	50% after \$25 copay
>> Inpatient Care	100% after \$200 copay	50% after \$200 copay
>> Residential Programs	100% after \$200 copay	50% after \$200 copay
<b>OTHER COVERED SERVICES</b>		
Allergy Injections	100% after \$5 copay	50% after \$5 copay
Ambulance, Ground	80%	80%
Ambulance, Air	50%	50%
Durable Medical Equipment	80%	50%
Home Health Care	80%	50%
* <b>Copay waived if admitted into hospital. In true medical emergencies, nonparticipating providers are paid at the participating provider level.</b>		
>> <b>Copay subject to 5-day maximum.</b>		
^ <b>No referral from PCP required.</b>		

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. To receive the maximum benefits under this plan, members should first seek treatment from their PCP.

**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.**