PacificSource HEALTH PLANS

Bend Chamber of Commerce

Medical Benefit Summary
PSN 3000+25-50_30 S2

Provider Network: PSN

Annual Deductible	Per Person, Per Calendar Year	Per Family, Per Calendar Year
All Providers	$3,000	$6,000
Out-of-Pocket Limit	**Per Person, Per Calendar Year**	**Per Family, Per Calendar Year**
Participating Providers	$6,850	$13,700
Non-participating Providers	$9,350	Not applicable

Please note: Your actual costs for services provided by a non-participating provider may exceed this policy's out-of-pocket limit for non-participating services. In addition, non-participating providers can bill you for the difference between the amount charged by the provider and the amount allowed by the insurance company, and this amount is not counted toward the non-participating out-of-pocket limit.

Accident Benefit

The first $1,000 of covered expenses within 90 days of an accident is covered up to the maximum benefit available and is not subject to the deductible. The date of injury must occur after the member is enrolled in this plan. If date of injury occurred prior to being enrolled on this plan, this benefit will not apply. The balance is covered as shown below.

The member is responsible for the above deductible and the following amounts:

Service	Participating Providers:	Non-participating Providers:
Preventive Care		
Well baby/Well child care	No charge*	Deductible then 50% co-insurance
Routine physicals	No charge*	Deductible then 50% co-insurance
Well woman visits	No charge*	Deductible then 50% co-insurance
Routine mammograms	No charge*	Deductible then 50% co-insurance
Immunizations	No charge*	Deductible then 50% co-insurance
Routine colonoscopy	No charge*	Deductible then 50% co-insurance
Prostate cancer screening	No charge*	Deductible then 50% co-insurance
Professional Services		
Office and home visits	$25 co-pay/visit*	Deductible then 50% co-insurance
Naturopath office visits	$25 co-pay/visit*	Deductible then 50% co-insurance
Specialist office and home visits	$50 co-pay/visit*	Deductible then 50% co-insurance
Telemedicine visits	$25 co-pay/visit*	Deductible then 50% co-insurance
Office procedures and supplies	Deductible then 30% co-insurance	Deductible then 50% co-insurance
Surgery	Deductible then 30% co-insurance	Deductible then 50% co-insurance
Outpatient rehabilitation and habilitation services	30% co-insurance*	Deductible then 50% co-insurance
Hospital Services		
Inpatient room and board	Deductible then 30% co-insurance	Deductible then 50% co-insurance
Inpatient rehabilitation and	Deductible then 30% co-insurance	Deductible then 50% co-insurance

Service	Participating Providers:	Non-participating Providers:
habilitation services		
Skilled nursing facility care	Deductible then 30% co-insurance	Deductible then 50% co-insurance
Outpatient Services		
Outpatient surgery/services	Deductible then 30% co-insurance	Deductible then 50% co-insurance
Advanced diagnostic imaging	Deductible then 30% co-insurance	Deductible then $100 co-pay/test plus 50% co-insurance
Diagnostic and therapeutic radiology/lab and dialysis	30% co-insurance*	Deductible then 50% co-insurance
Urgent and Emergency Services		
Urgent care center visits	$25 co-pay/visit*	Deductible then 50% co-insurance
Emergency room visits – medical emergency	$200 co-pay/visit plus 30% co-insurance*^	$200 co-pay/visit plus 30% co-insurance*^
Emergency room visits – non-emergency	$200 co-pay/visit plus 30% co-insurance*^	Deductible then 50% co-insurance
Ambulance, ground	Deductible then 30% co-insurance	Deductible then 30% co-insurance
Ambulance, air	Deductible then 30% co-insurance	Deductible then 30% co-insurance+
Maternity Services**		
Physician/Provider services (global charge)	Deductible then 30% co-insurance	Deductible then 50% co-insurance
Hospital/Facility services	Deductible then 30% co-insurance	Deductible then 50% co-insurance
Mental Health/Chemical Dependency Services		
Office visits	$25 co-pay/visit*	Deductible then 50% co-insurance
Inpatient care	Deductible then 30% co-insurance	Deductible then 50% co-insurance
Residential programs	Deductible then 30% co-insurance	Deductible then 50% co-insurance
Other Covered Services		
Allergy injections	$5 co-pay/visit*	Deductible then 50% co-insurance
Durable medical equipment	Deductible then 30% co-insurance	Deductible then 50% co-insurance
Home health care	Deductible then 30% co-insurance	Deductible then 50% co-insurance
Transplants	Deductible then No charge	Deductible then 50% co-insurance

This is a brief summary of benefits. Refer to your handbook for additional information or a further explanation of benefits, limitations, and exclusions.

^ Co-pay applies to ER physician and facility charges only. Co-pay waived if admitted into hospital.

* Not subject to annual deductible.

+ Please note that non-participating air ambulance coverage is covered at 500 percent of the Medicare allowable. Contact Customer Service with questions.

** Medically necessary services, medication, and supplies to manage diabetes during pregnancy from conception through six weeks postpartum will not be subject to a deductible, co-payment, or co-insurance.

Additional Information

What is the annual deductible?

Your plan's deductible is the amount of money that you pay first, before your plan starts to pay. You'll see that many services, especially preventive care, are covered by the plan without you needing to meet the deductible. The individual deductible applies if you enroll without dependents. If you and one or more dependents enroll, the individual deductible applies for each member only until the family deductible has been met. Deductible expense is applied to the out-of-pocket limit.

Participating provider expense and non-participating provider expense apply together toward your deductibles.

What is the out-of-pocket limit?

The out-of-pocket limit is the most you'll pay for covered medical expenses during the plan year. Once the out-of-pocket limit has been met, the plan will pay 100 percent of covered charges for the rest of that year. The individual out-of-pocket limit applies only if you enroll without dependents. If you and one or more dependents enroll, the individual out-of-pocket limit applies for each member only until the family out-of-pocket limit has been met. Be sure to check your Member Handbook, as there are some charges, such as non-essential health benefits, penalties and balance billed amounts that do not count toward the out-of-pocket limit.

Note that there is a separate category for participating and non-participating providers when it comes to meeting your out-of-pocket limit. Only participating provider expense applies to the participating provider out-of-pocket limit. Only non-participating provider expense applies to the non-participating provider out-of-pocket limit.

Payments to providers

Payment to providers is based on the prevailing or contracted PacificSource fee allowance for covered services. Participating providers accept the fee allowance as payment in full. Non-participating providers are allowed to balance bill any remaining balance that your plan did not cover. Services of non-participating providers could result in out-of-pocket expense in addition to the percentage indicated.

Preauthorization

Coverage of certain medical services and surgical procedures requires a benefit determination by PacificSource before the services are performed. This process is called 'preauthorization'. Preauthorization is necessary to determine if certain services and supplies are covered under this plan, and if you meet the plan's eligibility requirements. You'll find the most current preauthorization list on our website, PacificSource.com/member/preauthorization.aspx.

PacificSource HEALTH PLANS

Prescription Drug Benefit Summary
OR 10-50-75 S2 PDL

Bend Chamber of Commerce

This PacificSource health plan includes coverage for prescription drugs and certain other pharmaceuticals, subject to the information below. This plan complies with federal health care reform.

The amount you pay for covered prescriptions at participating and non-participating pharmacies applies towards your plan's participating medical out-of-pocket limit, which is shown on the Medical Benefit Summary. The co-payment and/or co-insurance for prescription drugs obtained from a participating or non-participating pharmacy are waived during the remainder of a calendar year in which you have satisfied the medical out-of-pocket limit.

PACIFICSOURCE PREVENTIVE RX

Your prescription benefit includes certain outpatient drugs as a preventive benefit at no charge*. This includes specific drugs that are taken regularly to prevent a disease or to keep a specific disease or condition from progressing. Preventive drugs are taken to help avoid many illnesses and conditions. You can get a list of covered preventive drugs by contacting our Customer Service team or visit PacificSource.com/drug-list/.

Each time a covered pharmaceutical is dispensed, you are responsible for the amounts below:

	Tier 1:	Tier 2:	Tier 3:
Participating Retail Pharmacy^			
Up to a 30 day supply:	$10 co-pay*	$50 co-pay*	$75 co-pay*
Participating Mail Order Pharmacy			
Up to a 30 day supply:	$10 co-pay*	$50 co-pay*	$75 co-pay*
31 - 90 day supply:	$20 co-pay*	$150 co-pay*	$225 co-pay*
Non-participating Pharmacy			
30 day max fill, no more than three fills allowed per year:	Same as retail		
Tier 4 Specialty Drugs – Participating Specialty Pharmacy			
Up to a 30 day supply:	20% co-insurance*		
Tier 4 Specialty Drugs – Not filled through Participating Specialty Pharmacy			
30 day max fill, no more than three fills allowed per year:	20% co-insurance*		
Compound Drugs**			
Up to 30 day supply:	$75 co-pay*		

^ *Remember to show your PacificSource member ID card each time you fill a prescription at a retail pharmacy. If your ID card is not used, your benefits cannot be applied and may result in higher out-of-pocket cost.*

* *Not subject to annual medical deductible.*

** *Compounded medications are subject to a preauthorization process. Compounds are generally covered only when all commercially available formulary products have been exhausted and all the ingredients in the compounded medication are on the applicable formulary.*

MAC B - Unless the prescribing provider requires the use of a brand name drug, the prescription will automatically be filled with a generic drug when available and permissible by state law. If you receive a brand name drug when a generic is available, you will be responsible for the brand name drug's co-payment and/or co-insurance plus the difference in cost between the brand name drug

and its generic equivalent. If your prescribing provider requires the use of a brand name drug, the prescription will be filled with the brand name drug and you will be responsible for the brand name drug's co-payment and/or co-insurance. The cost difference between the brand name and generic drug does not apply toward the medical plan's out-of-pocket limit.

If your physician prescribes a non-formulary contraceptive due to medical necessity it may be subject to preauthorization for coverage at no charge.

See your member handbook for important information about your prescription drug benefit, including which drugs are covered, limitations, and more.