Provider Network: SmartChoice

Annual Deductible	Per Person, Per Calendar Year	Per Family, Per Calendar Year
Participating Providers	$1,000	$2,000
Non-participating Providers	$5,000	$10,000
Out-of-Pocket Limit	**Per Person, Per Calendar Year**	**Per Family, Per Calendar Year**
Participating Providers	$5,000	$10,000
Non-participating Providers	$7,500	$15,000

Please note: Participating provider deductible and out-of-pocket limit accumulates separately from the non-participating provider deductible and out-of-pocket limit. Even though you may have the same benefit for participating and non-participating providers, 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. Please see 'allowable fee' in the definitions section of your handbook.

Accident Benefit

The first $500 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		
Primary care practitioner (PCP) Office and home visits	$20 co-pay/visit*	Deductible then 50% co-insurance
Naturopath office visits	$20 co-pay/visit*	Deductible then 50% co-insurance
Specialist office and home visits	$50 co-pay/visit*	Deductible then 50% co-insurance
Telemedicine visits	$20 co-pay/visit*	Deductible then 50% co-

Service	Participating Providers:	Non-participating Providers:
		insurance
Office procedures and supplies	Deductible then 20% co-insurance	Deductible then 50% co-insurance
Surgery	Deductible then 20% co-insurance	Deductible then 50% co-insurance
Outpatient rehabilitation services	Deductible then 20% co-insurance	Deductible then 50% co-insurance
Hospital Services		
Inpatient room and board	Deductible then 20% co-insurance	Deductible then 50% co-insurance
Inpatient rehabilitation services	Deductible then 20% co-insurance	Deductible then 50% co-insurance
Skilled nursing facility care	Deductible then 20% co-insurance	Deductible then 50% co-insurance
Outpatient Services		
Outpatient surgery/services	Deductible then 20% co-insurance	Deductible then 50% co-insurance
Advanced diagnostic imaging	Deductible then 20% co-insurance	Deductible then 50% co-insurance
Diagnostic and therapeutic radiology/lab and dialysis	Deductible then 20% co-insurance	Deductible then 50% co-insurance
Urgent and Emergency Services		
Urgent care center visits	$20 co-pay/visit*	Deductible then 50% co-insurance
Emergency room visits – medical emergency	Deductible then $250 co-pay/visit plus 20% co-insurance^	Deductible then $250 co-pay/visit plus 20% co-insurance^
Emergency room visits – non-emergency	Deductible then $250 co-pay/visit plus 20% co-insurance^	Deductible then $250 co-pay/visit plus 50% co-insurance^
Ambulance, ground	Deductible then 20% co-insurance	Deductible then 20% co-insurance
Ambulance, air	Deductible then 20% co-insurance	Deductible then 20% co-insurance+
Maternity Services **		
Physician/Provider services (global charge)	Deductible then 20% co-insurance	Deductible then 50% co-insurance
Hospital/Facility services	Deductible then 20% co-insurance	Deductible then 50% co-insurance
Mental Health/Chemical Dependency Services		
Office visits	$20 co-pay/visit*	Deductible then 50% co-insurance
Inpatient care	Deductible then 20% co-insurance	Deductible then 50% co-insurance
Residential programs	Deductible then 20% co-insurance	Deductible then 50% co-insurance
Other Covered Services		
Allergy injections	Deductible then 20% co-insurance	Deductible then 50% co-insurance
Durable medical equipment	Deductible then 20% co-insurance	Deductible then 50% co-insurance

Service	Participating Providers:	Non-participating Providers:
Home health services	Deductible then 20% co-insurance	Deductible then 50% co-insurance
Chiropractic manipulations and acupuncture	$20 co-pay/visit*	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.

** 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.

+ Non-participating air ambulance coverage is covered at 200 percent of the Medicare allowance. You may be held responsible for the amount billed in excess. Please see your handbook for additional information or contact our Customer Service team with questions.

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.

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

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.

Primary care practitioner

You must select and use a primary care practitioner (PCP) from the plan's provider directory. The PCP will coordinate healthcare resources to best meet your needs. Referrals are not required.

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 above.

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.

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

The amount you pay for covered prescriptions at participating and non-participating pharmacies applies toward 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 the 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*	$35 co-pay*	20% co-insurance*
Participating Mail Order Pharmacy			
Up to a 30 day supply:	$10 co-pay*	$35 co-pay*	20% co-insurance*
31 - 90 day supply:	$20 co-pay*	$105 co-pay*	20% co-insurance*
Non-participating Pharmacy			
30 day max fill, no more than three fills allowed per year:	Deductible then 90% co-insurance		
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:	Deductible then 90% co-insurance		
Compound Drugs**			
Up to a 30 day supply:	20% co-insurance*		

^ *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 A - Regardless of the reason or medical necessity, if you receive a brand name drug or if your physician prescribes 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 and generic drug. The cost difference between the brand name and generic drug does not apply toward the medical plan's out-of-pocket limit. Does not apply to tobacco cessation and

preventive bowel prep kit medications covered under USPSTF guidelines.

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.

PacificSource HEALTH PLANS

Vision Benefit Summary
Vision 150

The following shows the vision benefit available under this plan for enrolled members for all covered vision exams, lenses, and frames when performed or prescribed by a licensed ophthalmologist or licensed optometrist. Coverage for pediatric services will end on the last day of the month in which the enrolled member turns 19. Co-payment and/or co-insurance for covered charges apply to the medical plan's out-of-pocket limit.

If charges for a service or supply are less than the amount allowed, the benefit will be equal to the actual charge. If charges for a service or supply are greater than the amount allowed, the expense above the allowed amount is the member's responsibility and will not apply toward the member's medical plan deductible or out-of-pocket limit.

Member Responsibility

Service/Supply	Participating Providers:	Non-participating Providers:
Enrolled Members Age 18 and Younger		
Eye exam	No charge*	No charge* up to $40 maximum then 100% co-insurance
Vision hardware	No charge* up to $150 maximum then subject to participating providers medical deductible and co-insurance per calendar year	
Enrolled Members Age 19 and Older		
Eye exam	No charge*	No charge* up to $40 maximum then 100% co-insurance
Vision hardware	No charge* up to $150 maximum per calendar year	

* Not subject to annual deductible

Benefit Limitations: enrolled members age 18 and younger

- One vision exam every calendar year.
- One pair of glasses (lenses and frames) or contact lenses in lieu of glasses per calendar year.

Benefit Limitations: enrolled members age 19 and older

- One vision exam every calendar year.
- Vision hardware includes glasses (lenses and frames) or contact lenses in lieu of glasses per calendar year.

Exclusions

- Special procedures, such as orthoptics or vision training.
- Special supplies, such as sunglasses (plain or prescription) and subnormal vision aids.
- Lens tint.
- Plano contact lenses.
- Anti-reflective coating and scratch resistant coatings.
- Replacement of lost, stolen, or broken lenses or frames.
- Duplication of spare eyeglasses or any lenses or frames for members age 18 and younger.
- Nonprescription lenses.

- Visual analysis that does not include refraction.
- Services or supplies not listed as covered expenses.
- Eye exams required as a condition of employment, required by a labor agreement or government body.
- Expenses covered under any worker's compensation law.
- Services or supplies received before this plan's coverage begins or after it ends.
- Charges for services or supplies covered in whole or in part under any medical or vision benefits provided by the employer.
- Medical or surgical treatment of the eye.

Important information about your vision benefits

Your PacificSource group health plan includes coverage for vision services. To make the most of those benefits, it's important to keep in mind the following:

Participating Providers

PacificSource is able to add value to your vision benefits by contracting with a network of vision providers. Those providers offer vision services at discounted rates, which are passed on to you in your benefits.

Paying for Services

Please remember to show your current PacificSource ID card whenever you use your plan's benefits. Our provider contracts require participating providers to bill us directly whenever you receive covered services and supplies. Providers will verify your vision benefits. Participating providers should not ask you to pay the full cost in advance. They may only collect your share of the expense up front, such as co-payments and amounts over your plan's allowances. If you are asked to pay the entire amount in advance, tell the provider you understand they have a contract with PacificSource, and they should bill PacificSource directly.

Sales and Promotions (sales and promotions are not considered insurance)

Vision retailers often use coupons and promotions to bring in new business, such as free eye exams, two-for-one glasses, or free lenses with purchase of frames. Because participating providers already discount their services through their contract with PacificSource, your plan's participating provider benefits cannot be combined with any other discounts or coupons. You can use your plan's participating provider benefits, or you can use your plan's non-participating provider benefits to take advantage of a sale or coupon offer.

If you do take advantage of a special offer, the participating provider may treat you as an uninsured customer and require full payment in advance. You can then send the claim to PacificSource yourself, and we will reimburse you according to your plan's non-participating provider benefits.