Provider Network: SmartChoice

Annual Deductible	Per Person, Per Calendar Year	Per Family, Per Calendar Year
Participating Providers	$6,450	$12,900
Non-participating Providers	$10,000	$20,000
Out-of-Pocket Limit	**Per Person, Per Calendar Year**	**Per Family, Per Calendar Year**
Participating Providers	$6,450	$12,900
Non-participating Providers	$20,000	$40,000

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. Your cost for covered Vision Services do not accumulate toward the out-of-pocket limit if delivered by a non-participating provider. 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.

Participating provider deductible and out-of-pocket limit accumulates separately from the non-participating provider deductible and out-of-pocket limit.

American Indian and Alaska Native Benefits
Qualified Native Americans enrolled on this plan that receive services directly from, referred by, or ordered by the Indian Health Service, Indian Tribe, Tribal Organizations, or Urban Indian Organization will not be subject to deductible, co-payments, or co-insurance for those services. Please note: Even though you may have the same benefit for participating and non-participating providers, you may still be responsible for any amounts that a non-participating provider charges that are over the PacificSource allowable fee. Please see 'allowable fee' in the definitions section of your policy.

Accident Benefit
The first $500 of covered expenses within 90 days of an accident is covered at no charge and is not subject to 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, age 50-75	No charge*	Deductible then 50% co-insurance
Prostate cancer screening	No charge*	Deductible then 50% co-insurance
Professional Services		
Primary care provider (PCP) Office and home visits	Deductible then No charge	Deductible then 50% co-insurance
Specialist office and home visits	Deductible then No charge	Deductible then 50% co-insurance

Service	Participating Providers:	Non-participating Providers:
Office procedures and supplies	Deductible then No charge	Deductible then 50% co-insurance
Surgery	Deductible then No charge	Deductible then 50% co-insurance
Outpatient rehabilitation services	Deductible then No charge	Deductible then 50% co-insurance
Hospital Services		
Inpatient room and board	Deductible then No charge	Deductible then 50% co-insurance
Inpatient rehabilitation services	Deductible then No charge	Deductible then 50% co-insurance
Skilled nursing facility care	Deductible then No charge	Deductible then 50% co-insurance
Outpatient Services		
Outpatient surgery/services	Deductible then No charge	Deductible then 50% co-insurance
Advanced diagnostic imaging	Deductible then No charge	Deductible then 50% co-insurance
Diagnostic and therapeutic radiology and lab	Deductible then No charge	Deductible then 50% co-insurance
Urgent and Emergency Services		
Urgent care center visits	Deductible then No charge	Deductible then 50% co-insurance
Emergency room visits – medical emergency	Deductible then No charge	Deductible then No charge
Emergency room visits – non-emergency	Deductible then No charge	Deductible then 50% co-insurance
Ambulance, ground	Deductible then No charge	Deductible then No charge
Ambulance, air	Deductible then No charge	Deductible then No charge
Maternity Services		
Physician/Provider services (global charge)	Deductible then No charge	Deductible then 50% co-insurance
Hospital/Facility services	Deductible then No charge	Deductible then 50% co-insurance
Mental Health/Chemical Dependency Services		
Office visits	Deductible then No charge	Deductible then 50% co-insurance
Inpatient care	Deductible then No charge	Deductible then 50% co-insurance
Residential programs	Deductible then No charge	Deductible then 50% co-insurance
Other Covered Services		
Allergy injections	Deductible then No charge	Deductible then 50% co-insurance
Durable medical equipment	Deductible then No charge	Deductible then 50% co-insurance
Home health care	Deductible then No charge	Deductible then 50% co-insurance
Chiropractic manipulation and Acupuncture	Deductible then No charge	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 policy for additional information or a further explanation of benefits, limitations, and exclusions.

* Not subject to annual deductible.

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 policy, 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 and only non-participating provider expense applies to the non-participating provider out-of-pocket limit.

Annual change in deductible and/or out-of-pocket limit amounts

This plan's deductible and/or out-of-pocket limit amounts may be automatically adjusted upward every January 1 based on the rules set forth by Health and Human Services (HHS).

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.

This benefit allows you to receive services from licensed providers for chiropractic manipulation and acupuncture care for medically necessary treatment of illness or injury. The service must be within the scope of the provider's license. Refer to the Medical Schedule of Benefits for your deductible, co-payment, and/or co-insurance information.

Covered Services

- Acupuncture from a licensed provider for medically necessary treatment of illness or injury.
- Chiropractic manipulations from a licensed provider for medically necessary treatment of illness or injury.

The combined benefit for all chiropractic manipulation and acupuncture care is limited to 15 visits per person per calendar year.

Excluded Services

- Any service or supply noted as being excluded or not otherwise covered by the medical plan.
- Homeopathic medicines or homeopathic supplies.
- Massage therapy.

The following shows the vision benefit available under this plan for enrolled members for all vision exams, lenses, and frames when performed or prescribed by a licensed ophthalmologist or licensed optometrist. Co-payment and/or co-insurance for covered charges do not 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. To find a VSP Choice participating provider, go to vsp.com or contact VSP member services at (800) 877-7195.

Member Responsibility

Service/Supply	VSP Providers:	Non-VSP Providers:
Enrolled Members Age 18 and Younger		
WellVision exam	No charge*	50% co-insurance*
Vision Hardware		
Single vision lenses	No charge*	50% co-insurance*
Bifocal lenses	No charge*	50% co-insurance*
Trifocal lenses	No charge*	50% co-insurance*
Lenticular lenses	No charge*	50% co-insurance*
Frames	No charge*	50% co-insurance*
Contact Lenses (in lieu of glasses)		
Contact lenses - fitting and materials (minimum three month supply)	No charge*	50% co-insurance*

* Not subject to annual deductible

Benefit Limitations: enrolled members age 18 and younger

A limited collection of pediatric frames in a variety of styles and colors. All frames provided through a VSP provider have a one-year manufacturer's warranty, and lenses come with polycarbonate, scratch coating and ultraviolet protection included.

- One vision exam every calendar year.
- One pair per calendar year, lenses and frames from the Pediatric Exchange Collection.
- In lieu of eyeglasses, elective contact lens services and materials are covered with the following limitations per calendar year:
    - Standard = 1 contact lens per eye (total 2 lenses); or

- Monthly = 6 lenses per eye (total 12 lenses); or
- Bi-weekly = 6 lenses per eye (total 12 lenses); or
- Dailies = 90 lenses per eye (total 180 lenses).

Exclusions and limitations of benefits

Some brands of spectacle frames may be unavailable for purchase as plan benefits, or may be subject to additional limitations. Covered members may obtain details regarding frame brand availability from their VSP Network Doctor or by calling VSP's Customer Care Division at (800) 877-7195.

This Plan is designed to cover visual needs rather than cosmetic materials. When the covered member selects any of the following extras, the plan will pay the basic cost of the allowed lenses or frames, and the covered member will pay the additional costs for the options.

- Optional cosmetic processes
- Anti-reflective coating
- Color coating
- Mirror coating
- Blended lenses
- Cosmetic lenses
- Laminated lenses
- Oversize lenses
- Progressive multifocal lenses
- Photochromic lenses, tinted lenses except Pink #1 and Pink #2
- Certain limitations on low vision care

Exclusions

There are no benefits for professional services or materials connected with:

- Orthoptics or vision training and any associated supplemental testing
- Plano lenses (less than a $\pm$ .50 diopter power)
- Two pair of glasses in lieu of bifocals
- Replacement of lenses and frames furnished under this policy that are lost or broken, except at the normal intervals when services are otherwise available
- Medical or surgical treatment of the eyes
- Corrective vision treatment of an experimental nature

- Costs for services and/or materials above plan benefit allowances
- Services and/or materials not indicated on this benefit schedule as covered plan benefits

Important information about your vision benefits

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

Extra Discounts through VSP Providers (sales and promotions are not considered insurance)

- 20 percent savings on additional prescription glasses and non-prescription sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam.
- 15 percent discount on covered fitting and evaluations for elective contact lenses.
- Average 15 percent off the regular price or 5 percent off the promotional price on laser vision correction; discounts only available from contracted facilities.

Participating Providers

PacificSource is able to add value to your vision benefits by contracting with VSP vision providers. Those providers offer vision services at discounted rates, which are passed on to you in your benefits. To find a VSP Choice participating provider, go to vsp.com or contact VSP member services at (800) 877-7195.

Paying for Services

Please remember to show your current PacificSource ID card whenever you use your plan's benefits. VSP network doctors will verify your vision benefits. VSP network doctors 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 VSP and they should bill VSP directly.

If you receive services or materials from a non-participating provider, VSP makes payment up to the amount stated in the Vision Schedule of Benefits for non-participating providers as follows:

- The provider may submit the claim directly to VSP for the non-participating benefit amount. In this case, you pay any overage at time of service.
- If not, you are responsible for sending the claim to VSP for processing. Your claim must include a copy of your provider's itemized bill and VSP's out-of-network reimbursement form. All claims should be sent to:

VSP
PO Box 997105
Sacramento, CA 95899-7105

All claims for benefits must be turned into VSP within 90 days of the date of service. If it is not possible to submit a claim within 90 days, turn in the claim with an explanation as soon as possible. In some cases VSP may accept the claim late. We will never pay a claim that was submitted more than twelve months after the date of service.

This PacificSource health plan includes coverage for prescription drugs and certain other pharmaceuticals, subject to the information below. This prescription drug plan does not qualify as creditable coverage for Medicare Part D.

MEDICAL PLAN DEDUCTIBLE

You must satisfy the medical plan deductible, shown on the Medical Schedule of Benefits, before your prescription drug benefits begin for generic, preferred brand name, non-preferred, compound, and/or specialty prescription drugs.

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

American Indian and Alaska Native Benefits

Qualified Native Americans enrolled on this plan that receive services directly from, referred by, or ordered by the **Indian Health Service**, **Indian Tribe, Tribal Organizations, or Urban Indian Organization** will not be subject to deductible, co-payments, or co-insurance for those services.

PREVENTIVE CARE DRUGS

Your prescription benefit includes certain outpatient drugs as a preventive benefit at no charge*. This benefit includes some drugs required by federal health care reform. It also includes specific generic drugs that are taken regularly to prevent a disease or to keep a specific disease or condition from coming back after recovery. Preventive drugs do not include drugs for treating an existing illness, injury or condition. You can get a list of covered preventive drugs by calling Customer Service. You can also get this list by visiting our website at PacificSource.com/drug-list/.

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

	Tier 1: Generic	Tier 2: Preferred	Tier 3: Non-preferred
Participating Retail Pharmacy^			
Up to a 30 day supply:	Deductible then No charge	Deductible then No charge	Deductible then No charge
Participating Mail Order Pharmacy			
Up to a 30 day supply:	Deductible then No charge	Deductible then No charge	Deductible then No charge
31 - 90 day supply:	Deductible then No charge	Deductible then No charge	Deductible then No charge
Non-participating Pharmacy			
Regardless of tier, limited to a 30 day supply per fill, up to a 90 day supply per calendar year:	Deductible then 90% co-insurance		
Tier 4 Specialty Drugs – Participating Specialty Pharmacy			
Up to a 30 day supply:	Deductible then No charge		
Tier 4 Specialty Drugs – Not filled through Participating Specialty Pharmacy			

	Tier 1: Generic	Tier 2: Preferred	Tier 3: Non-preferred
Regardless of tier, limited to a 30 day supply per fill, up to a 90 day supply per calendar year:	Deductible then 90% co-insurance		
Compound Drugs**			
Up to a 30 day supply:	Deductible then No charge		

^ Remember to show your PacificSource ID Card each time you fill a prescription at a retail pharmacy. If your ID card is not used, the benefits will be the same as the non-participating pharmacy benefit.

** Not subject to annual medical deductible.*

**Compounded medications are subject to a Prior Authorization process. Compounds are generally covered only when all commercially available formulary products have been exhausted and compounded ingredients 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 after the medical deductible is met. 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 brand name contraceptive due to medical necessity when a generic contraceptive is available, the drug will be covered at no charge.

See your policy for important information about your prescription drug benefit, including which drugs are covered, how the tiers work, limitations and more.