| Deductible Per Calendar Year | In-network and Out-of-network | |
|---|---|---|
| **Individual/Family** | $1,500 / $3,000 | |
| **Out-of-Pocket Limit Per Calendar Year** | **In-network** | **Out-of-network** |
| **Individual/Family** | $5,000 / $10,000 | $5,000 / $10,000 |

**Note:** Your actual costs for services provided by an out-of-network provider may exceed this plan's out-of-pocket limit for out-of-network services. In addition, out-of-network 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 out-of-network out-of-pocket limit. Please see allowable fee in the Definitions section of your member handbook.

## Accident Benefit

The first $1,000 of covered expenses within 90 days of an accident is covered up to the maximum benefit available and 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 any amounts shown above, in addition to the following amounts:

| Service/Supply | In-network Member Pays | Out-of-network Member Pays |
|---|---|---|
| **Preventive Care** | | |
| **Well baby/Well child care** | No deductible, 0% | After deductible, 50% |
| **Preventive physicals** | No deductible, 0% | After deductible, 50% |
| **Well woman visits** | No deductible, 0% | After deductible, 50% |
| **Preventive mammograms** | No deductible, 0% | After deductible, 50% |
| **Immunizations** | No deductible, 0% | After deductible, 50% |
| **Preventive colonoscopy** | No deductible, 0% | After deductible, 50% |
| **Prostate cancer screening** | No deductible, 0% | After deductible, 50% |
| **Professional Services** | | |
| **Primary care provider (PCP) Office and home visits** | No deductible, $25 | After deductible, 50% |
| **Naturopath office visits** | No deductible, $25 | After deductible, 50% |
| **Specialist office and home visits** | No deductible, $50 | After deductible, 50% |
| **Telemedicine visits** | No deductible, $10 | After deductible, 50% |
| **Office procedures and supplies** | After deductible, 30% | After deductible, 50% |
| **Surgery** | After deductible, 30% | After deductible, 50% |
| **Outpatient rehabilitation and habilitation services** | No deductible, 30% | After deductible, 50% |
| **Chiropractic manipulations and acupuncture ($1,000 per benefit year.)** | No deductible, $25 | After deductible, 50% |

| Service/Supply | In-network Member Pays | Out-of-network Member Pays |
|---|---|---|
| **Hospital Services** | | |
| **Inpatient room and board** | After deductible, 30% | After deductible, 50% |
| **Inpatient rehabilitation and habilitation services** | After deductible, 30% | After deductible, 50% |
| **Skilled nursing facility care** | After deductible, 30% | After deductible, 50% |
| **Outpatient Services** | | |
| **Outpatient surgery/services** | After deductible, 30% | After deductible, 50% |
| **Advanced diagnostic imaging** | After deductible, 30% | After deductible, $100 plus 50% |
| **Diagnostic and therapeutic radiology / lab and dialysis** | No deductible, 30% | After deductible, 50% |
| **Urgent and Emergency Services** | | |
| **Urgent care center visits** | No deductible, $50 | After deductible, 50% |
| **Emergency room visits – medical emergency** | No deductible, $250 plus 30%^ | No deductible, $250 plus 30%^ |
| **Emergency room visits – non-emergency** | No deductible, $250 plus 30%^ | After deductible, 50% |
| **Ambulance, ground** | After deductible, 30% | After deductible, 30% |
| **Ambulance, air** | After deductible, 30% | After deductible, 30%+ |
| **Maternity Services**** | | |
| **Physician/Provider services (global charge)** | After deductible, 30% | After deductible, 50% |
| **Hospital/Facility services** | After deductible, 30% | After deductible, 50% |
| **Mental Health and Substance Use Disorder Services** | | |
| **Office visits** | No deductible, $25 | After deductible, 50% |
| **Inpatient care** | After deductible, 30% | After deductible, 50% |
| **Residential programs** | After deductible, 30% | After deductible, 50% |
| **Other Covered Services** | | |
| **Allergy injections** | No deductible, $5 | After deductible, 50% |
| **Durable medical equipment** | After deductible, 30% | After deductible, 50% |
| **Home health services** | After deductible, 30% | After deductible, 50% |
| **Transplants** | After deductible, 0% | After deductible, 50% |

**This is a brief summary of benefits. Refer to your member 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.

** 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.

+ Out-of-network air ambulance coverage is covered at 500 percent of the Medicare allowance. You may be held responsible for the amount billed in excess. Please see your member handbook for additional information or contact our Customer Service team with questions.

# Additional information

## What is the 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.

In-network expense and out-of-network expense apply together toward your deductible.

## What is the out-of-pocket limit?

The out-of-pocket limit is the most you'll pay for covered expenses during the plan year. Once the out-of-pocket limit has been met, the plan will pay 100 percent of allowed amounts for covered services 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 in-network and out-of-network when it comes to meeting your out-of-pocket limit. Only in-network expense applies to the in-network out-of-pocket limit Only out-of-network expense applies to the out-of-network out-of-pocket limit.

## Primary care physician or primary care provider (PCP)

You are highly encouraged to select a 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. In-network providers accept the fee allowance as payment in full. Out-of-network providers are allowed to balance bill any remaining balance that your plan did not cover. Services of out-of-network 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. Preauthorization does not change your out-of-pocket expense for in-network and out-of-network providers. 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 ODL

Bend Chamber of Commerce

**Formulary:** Oregon Drug List (ODL)

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. To check which tier your prescription falls under, call our Customer Service team or visit PacificSource.com/drug-list.

The amount you pay for covered prescriptions at in-network and out-of-network pharmacies applies toward your plan's in-network 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 an in-network or out-of-network pharmacy are waived during the remainder of the calendar year in which you have satisfied the medical out-of-pocket limit.

### PacificSource Expanded (Preventive) No-cost Drug List and Affordable Care Act Standard Preventive No-cost Drug List

Your prescription benefit includes certain outpatient drugs as a preventive benefit at no deductible, $0. This includes specific drugs that are taken regularly to prevent a disease or to keep a specific disease or condition from progressing. 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 prescription is dispensed, you are responsible for any amounts shown above, in addition to the following amounts:

| Service/ Supply | Tier 1 Member Pays | Tier 2 Member Pays | Tier 3 Member Pays | Tier 4 Member Pays |
|---|---|---|---|---|
| **In-network Retail Pharmacy** | | | | |
| **Up to a 30 day supply:** | No deductible, $10 | No deductible, $50 | No deductible, $75 | No deductible, 20% |
| **31 - 60 day supply:** | No deductible, $20 | No deductible, $100 | No deductible, $150 | No deductible, 20% |
| **61 - 90 day supply:** | No deductible, $30 | No deductible, $150 | No deductible, $225 | No deductible, 20% |
| **In-network Mail Order Pharmacy** | | | | |
| **Up to a 30 day supply:** | No deductible, $10 | No deductible, $50 | No deductible, $75 | No deductible, 20% |
| **31 - 90 day supply:** | No deductible, $20 | No deductible, $150 | No deductible, $225 | No deductible, 20% |
| **Compound Drugs**** | | | | |
| **Up to a 30 day supply:** | No deductible, $75 | | | |
| **31 - 60 day supply:** | No deductible, $150 | | | |
| **61 - 90 day supply:** | No deductible, $225 | | | |

| Service/ Supply | Tier 1 Member Pays | Tier 2 Member Pays | Tier 3 Member Pays | Tier 4 Member Pays |
|---|---|---|---|---|
| **Out-of-network Pharmacy** | | | | |
| **30 day max fill, no more than three fills allowed per year:** | | | Same as retail | |

**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 medications are on the applicable formulary.

Specialty Medications must be filled through an in-network specialty pharmacy and are limited to a 30 day supply.

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 medical plan's out-of-pocket limit. Does not apply to preventive bowel prep kit medications covered under USPSTF guidelines.

If your provider prescribes a brand name 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.**