PacificSource HEALTH PLANS

Medical Benefit Summary
Navigator 1500+25-50_30 S2

Bend Chamber of Commerce

Benefit Year: Calendar Year

Provider Network: Navigator

Deductible Per Benefit Year	In-network and Out-of-network	
Individual/Family	$1,500/$3,000	
Out-of-Pocket Limit Per Benefit Year	**In-network**	**Out-of-network**
Individual/Family	$6,000/$12,000	$6,000/$12,000

Note: Your actual costs for services provided out-of-network may exceed this plan's out-of-pocket limit for out-of-network services. In addition, out-of-network providers may in certain circumstances bill you for the difference between the amount charged by the provider and the amount allowed by the insurance company (called balance billing). Balance billing amounts are not counted toward the out-of-network out-of-pocket limit. For additional information about balance billing or allowable fees, see your handbook.

Accident Benefit

The first $1,000 of covered services 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		
Office and home visits	No deductible, $25	After deductible, 50%
Naturopath office visits	No deductible, $25	After deductible, 50%

Service/Supply	In-network Member Pays	Out-of-network Member Pays
Specialist office and home visits	No deductible, $50	After deductible, 50%
Telemedicine visits	No deductible, 0%	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 manipulation/Spinal manipulation (20 visits per benefit year)	No deductible, $25	After deductible, 50%
Acupuncture (12 visits per benefit year)	No deductible, $25	After deductible, 50%
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%
Diagnostic imaging – advanced	After deductible, 30%	After deductible, $100 plus 50%
Diagnostic and therapeutic radiology/laboratory and dialysis – non-advanced	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%

Service/Supply	In-network Member Pays	Out-of-network Member Pays
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 handbook for additional information or a further explanation of benefits, limitations, and exclusions.

^ Copay applies to ER physician and facility charges only. Copay 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, copayment, or coinsurance.

+ 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 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.

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 services during the benefit 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 benefit 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 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.

Payments to providers

Payment to providers is based on the prevailing or allowable fee for covered services. In-network providers accept the allowable fee as payment in full. Services of out-of-network providers could result in out-of-pocket expense in addition to the percentage indicated.

Prior authorization

Coverage of certain medical services and surgical procedures requires a benefit determination by PacificSource before the services are performed. This process is called prior authorization. Prior authorization is necessary to determine if certain services and supplies are covered under this plan, and if you meet the plan's eligibility requirements. Prior authorization does not change your out-of-pocket expense for in-network and out-of-network providers. You can search for procedures and services that require prior authorization on our website at Authgrid.PacificSource.com (select Commercial for the line of business).

Discrimination is against the law

PacificSource Health Plans complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. PacificSource does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

PacificSource HEALTH PLANS

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

Bend Chamber of Commerce

Formulary: Oregon Drug List (ODL)

Benefit Year: Calendar Year

This 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/find-a-drug.

The amount you pay for covered prescriptions at in-network pharmacies applies toward your plan's in-network medical out-of-pocket limit, the amount you pay for covered prescriptions at out-of-network pharmacies applies toward your plan's out-of-network out-of-pocket limit which is shown on the Medical Benefit Summary. The copayment and/or coinsurance for prescription drugs obtained from an in-network or out-of-network pharmacy are waived during the remainder of the benefit year in which you have satisfied the medical out-of-pocket limit.

PacificSource Expanded (Preventive) No-cost Drug List

Your prescription benefit includes certain outpatient drugs as a preventive benefit at no deductible, $0 copay. 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 and select Find a Drug.

Affordable Care Act Standard Preventive No-cost Drug List

Your prescription benefit includes preventive care drugs at no cost to you and are not subject to a deductible or MAC penalties. This benefit includes some drugs required by the Affordable Care Act, including tobacco cessation drugs. These drugs are identified on the drug list as Tier 0.

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, 30%
31 - 60 day supply:	No deductible, $20	No deductible, $100+	No deductible, $150+	No deductible, 30%
61 - 90 day supply:	No deductible, $30	No deductible, $150+	No deductible, $225+	No deductible, 30%
In-network Mail Order Pharmacy				
Up to a 30 day supply:	No deductible, $10	No deductible, $50+	No deductible, $75+	No deductible, 30%
31 - 90 day supply:	No deductible, $20	No deductible, $150+	No deductible, $225+	No deductible, 30%
Compound Drugs**				

Service/ Supply	Tier 1 Member Pays	Tier 2 Member Pays	Tier 3 Member Pays	Tier 4 Member Pays
Up to a 30 day supply:		No deductible, $75		
31 - 60 day supply:		No deductible, $150		
61 to 90 day supply:		No deductible, $225		
Out-of-network Pharmacy				
30 day maximum fill, no more than three fills allowed per year:		Same as retail		

+Formulary prescription insulin will not be subject to a deductible and may not exceed $75 per 30 day supply.

**Compounded medications are subject to a prior authorization 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 copayment and/or coinsurance 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 copayment and/or coinsurance. 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 preventive bowel prep kits covered under USPSTF guidelines.

If your provider prescribes a brand name contraceptive due to medical necessity it may be subject to prior authorization for coverage at no charge.

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