### Accident Benefit

The first $500 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 the above deductible and the following amounts:

<table>
<thead>
<tr>
<th>Service/Supply</th>
<th>In-network Member Pays</th>
<th>Out-of-network Member Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Preventive Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Well baby/Well child care</td>
<td>No deductible, 0%</td>
<td>After deductible, 50%</td>
</tr>
<tr>
<td>Preventive physicals</td>
<td>No deductible, 0%</td>
<td>After deductible, 50%</td>
</tr>
<tr>
<td>Well woman visits</td>
<td>No deductible, 0%</td>
<td>After deductible, 50%</td>
</tr>
<tr>
<td>Preventive mammograms</td>
<td>No deductible, 0%</td>
<td>After deductible, 50%</td>
</tr>
<tr>
<td>Immunizations</td>
<td>No deductible, 0%</td>
<td>After deductible, 50%</td>
</tr>
<tr>
<td>Preventive colonoscopy</td>
<td>No deductible, 0%</td>
<td>After deductible, 50%</td>
</tr>
<tr>
<td>Prostate cancer screening</td>
<td>No deductible, 0%</td>
<td>After deductible, 50%</td>
</tr>
<tr>
<td><strong>Professional Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary care provider (PCP) Office and home visits</td>
<td>No deductible, $35</td>
<td>After deductible, 50%</td>
</tr>
<tr>
<td>Naturopath office visits</td>
<td>No deductible, $35</td>
<td>After deductible, 50%</td>
</tr>
<tr>
<td>Specialist office and home visits</td>
<td>After deductible, 40%</td>
<td>After deductible, 50%</td>
</tr>
<tr>
<td>Service/Supply</td>
<td>In-network Member Pays</td>
<td>Out-of-network Member Pays</td>
</tr>
<tr>
<td>----------------------------------------------------</td>
<td>-----------------------------------</td>
<td>----------------------------------</td>
</tr>
<tr>
<td>Telemedicine visits</td>
<td>No deductible, $10</td>
<td>After deductible, 50%</td>
</tr>
<tr>
<td>Office procedures and supplies</td>
<td>After deductible, 40%</td>
<td>After deductible, 50%</td>
</tr>
<tr>
<td>Surgery</td>
<td>After deductible, 40%</td>
<td>After deductible, 50%</td>
</tr>
<tr>
<td>Outpatient rehabilitation services</td>
<td>After deductible, 40%</td>
<td>After deductible, 50%</td>
</tr>
<tr>
<td>Chiropractic manipulation and Acupuncture ($1,000 per year)</td>
<td>After deductible, 40%</td>
<td>After deductible, 50%</td>
</tr>
<tr>
<td><strong>Hospital Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient room and board</td>
<td>After deductible, 40%</td>
<td>After deductible, 50%</td>
</tr>
<tr>
<td>Inpatient rehabilitation services</td>
<td>After deductible, 40%</td>
<td>After deductible, 50%</td>
</tr>
<tr>
<td>Skilled nursing facility care</td>
<td>After deductible, 40%</td>
<td>After deductible, 50%</td>
</tr>
<tr>
<td><strong>Outpatient Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient surgery/services</td>
<td>After deductible, 40%</td>
<td>After deductible, 50%</td>
</tr>
<tr>
<td>Advanced diagnostic imaging</td>
<td>After deductible, 40%</td>
<td>After deductible, 50%</td>
</tr>
<tr>
<td>Diagnostic and therapeutic radiology/lab and dialysis</td>
<td>After deductible, 40%</td>
<td>After deductible, 50%</td>
</tr>
<tr>
<td><strong>Urgent and Emergency Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgent care center visits</td>
<td>No deductible, $35</td>
<td>After deductible, 50%</td>
</tr>
<tr>
<td>Emergency room visits – medical emergency</td>
<td>After deductible, 40%</td>
<td>After deductible, 40%</td>
</tr>
<tr>
<td>Emergency room visits – non-emergency</td>
<td>After deductible, 40%</td>
<td>After deductible, 50%</td>
</tr>
<tr>
<td>Ambulance, ground</td>
<td>After deductible, 40%</td>
<td>After deductible, 40%</td>
</tr>
<tr>
<td>Ambulance, air</td>
<td>After deductible, 40%</td>
<td>After deductible, 40%+</td>
</tr>
<tr>
<td><strong>Maternity Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician/Provider services (global charge)</td>
<td>After deductible, 40%</td>
<td>After deductible, 50%</td>
</tr>
<tr>
<td>Hospital/Facility services</td>
<td>After deductible, 40%</td>
<td>After deductible, 50%</td>
</tr>
<tr>
<td><strong>Mental Health and Substance Use Disorder Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office visits</td>
<td>No deductible, $35</td>
<td>After deductible, 50%</td>
</tr>
<tr>
<td>Inpatient care</td>
<td>After deductible, 40%</td>
<td>After deductible, 50%</td>
</tr>
<tr>
<td>Residential programs</td>
<td>After deductible, 40%</td>
<td>After deductible, 50%</td>
</tr>
<tr>
<td><strong>Other Covered Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allergy injections</td>
<td>After deductible, 40%</td>
<td>After deductible, 50%</td>
</tr>
<tr>
<td>Service/Supply</td>
<td>In-network Member Pays</td>
<td>Out-of-network Member Pays</td>
</tr>
<tr>
<td>------------------------</td>
<td>-------------------------</td>
<td>----------------------------</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>After deductible, 40%</td>
<td>After deductible, 50%</td>
</tr>
<tr>
<td>Home health services</td>
<td>After deductible, 40%</td>
<td>After deductible, 50%</td>
</tr>
<tr>
<td>Transplants</td>
<td>After deductible, 0%</td>
<td>After deductible, 50%</td>
</tr>
</tbody>
</table>

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

** 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 200 percent of the Medicare allowance. You may be held responsible for the amount billed in excess. Please see your policy for additional information or contact our Customer Service team with questions.
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.

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

Primary care physician or primary care provider (PCP)

You must 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.
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 No Cost Drug List

Your prescription benefit includes certain outpatient drugs as a preventive benefit: 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. 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 to view the PacificSource Expanded No Cost Drug List.

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

<table>
<thead>
<tr>
<th>Service/Supply</th>
<th>Tier 1 Member Pays</th>
<th>Tier 2 Member Pays</th>
<th>Tier 3 Member Pays</th>
<th>Tier 4 Member Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-network Retail Pharmacy^</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Up to a 30 day supply:</td>
<td>No deductible, $15</td>
<td>No deductible, $60</td>
<td>No deductible, 40%</td>
<td>No deductible, 40%</td>
</tr>
<tr>
<td>31 - 60 day supply:</td>
<td>No deductible, $30</td>
<td>No deductible, $120</td>
<td>No deductible, 40%</td>
<td>No deductible, 40%</td>
</tr>
<tr>
<td>61 - 90 day supply:</td>
<td>No deductible, $45</td>
<td>No deductible, $180</td>
<td>No deductible, 40%</td>
<td>No deductible, 40%</td>
</tr>
<tr>
<td>In-network Mail Order Pharmacy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Up to a 30 day supply:</td>
<td>No deductible, $15</td>
<td>No deductible, $60</td>
<td>No deductible, 40%</td>
<td>No deductible, 40%</td>
</tr>
<tr>
<td>31 - 90 day supply:</td>
<td>No deductible, $30</td>
<td>No deductible, $180</td>
<td>No deductible, 40%</td>
<td>No deductible, 40%</td>
</tr>
<tr>
<td>Compound Drugs**</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Up to a 30 day supply:</td>
<td>No deductible, 40%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>31 - 60 day supply:</td>
<td>No deductible, 40%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>61 - 90 day supply:</td>
<td>No deductible, 40%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Out-of-network Pharmacy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
30 day max fill, no more than three fills allowed per year:  

After deductible, 90%

^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.

**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 A - Regardless of the reason or medical necessity, if you receive a brand name drug or if your provider 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 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.
The following shows the vision benefits 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.

### Service/Supply

<table>
<thead>
<tr>
<th>Service/Supply</th>
<th>In-network Member Pays</th>
<th>Out-of-network Member Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enrolled Members Age 18 and Younger</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eye exam</td>
<td>No deductible, 0%</td>
<td>No deductible up to $40 then 100%</td>
</tr>
<tr>
<td>Vision hardware</td>
<td>No deductible up to $150 then subject to in-network deductible and 40%</td>
<td></td>
</tr>
</tbody>
</table>

### Benefit Limitations: enrolled members age 18 and younger
- One vision exam every calendar year.
- Vision hardware includes one pair of glasses (lenses and frames) or contacts (lenses and fitting) once per calendar year.

### Exclusions
- Charges for services or supplies covered in whole or in part under any medical or vision benefits provided by an employer.
- Expenses covered under any worker’s compensation law.
- Eye exams required as a condition of employment, required by a labor agreement or government body.
- Medical or surgical treatment of the eye.
- Nonprescription lenses.
- Plano contact lenses.
- Services or supplies not listed as covered expenses.
- Services or supplies received before this plan’s coverage begins or after it ends.
- Special procedures, such as orthoptics or vision training.
- Visual analysis that does not include refraction.
Important information about your vision benefits

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

**In-network 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 member ID card whenever you use your plan’s benefits. Our provider contracts require in-network providers to bill us directly whenever you receive covered services and supplies. Providers will verify your vision benefits.

In-network 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 Special 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 in-network providers already discount their services through their contract with PacificSource, your plan’s in-network provider benefits cannot be combined with any other discounts or coupons. You can use your plan’s in-network provider benefits, or you can use your plan’s out-of-network provider benefits to take advantage of a sale or coupon offer.

If you do take advantage of a special offer, the in-network 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 out-of-network provider benefits.