PacificSource: PREFERRED CODEDUCT VALUE 3000+35/70% 0812

Coverage Period: 04/01/2013 - 03/31/2014

Summary of Benefits and Coverage: What this plan Covers and What it Costs **Coverage for:** Individual + Family **Plan Type**: PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at PacificSource.com or by calling 1-888-977-9299.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$3000 person / $9000 family Doesn't apply to preventive care except preventive colonoscopies from a non-participating provider, office visits, and emergency room.	You must pay all the costs up to the deductible amount before thisplan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, butnot always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see thechart starting on page 2 for other costs for services this plan covers.
Is there anout-of-pocket limit on my expenses?	Yes. $5000 person participating provider $8000 person non-participating provider $10000 family participating provider	The out-of-pocket limit is the most you could pay during a coverageperiod (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket	Premiums, deductibles, co-pays, pharmacy, balanced-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *speciJic* covered services, such as officevisits.
Does this plan use a networkof providers?	Yes. For a list of preferred providers, see PacificSource.com orcall 1-888-977-9299	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred,or participating for providers in their network. See the chart startingon page 2 for how this plan pays different kinds of
Do I need a referral to see a specialist?	No.	You can see the specialist you choose without permission from thisplan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about excluded services.

- Co-payments are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- Co-insurance is *your* share of the costs of a covered service, calculated as a percent of the allowed amount for the service. For example, ifthe plans allowed amount for an overnight hospital stay is $1,000, your co-insurance payment of 20% would be $200. This may change ifyou haven't met your deductible.
- The amount the plan pays for covered services is based on the allowed amount. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and theallowed amount is $1,000, you may have to pay the $500 difference. (This is called balance billing.)
- This plan may encourage you to use participating providers by charging you lower deductibles, co-payments and co-insurance

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you visit a healthcare provider's office or clinic	Primary care visit to treat an injury or illness	$35 co-pay/visit	$35 co-pay/visit plus 30% co-insurance	---none---
	Specialist visit	$35 co-pay/visit	$35 co-pay/visit plus 30% co-insurance	---none---
	Other practitioner office visit Acupuncture	Not covered	Not covered	No coverage forAcupuncture.
	Naturopath	Not covered	Not covered	No coverage forNaturopath.
	Chiropractic	Not covered	Not covered	No coverage for Chiropractic.
	Care Massage Therapy	Not covered	Not covered	No coverage for MassageTherapy.
	Preventive care/screening/immunization	No charge	30% co-insurance	Limited to: Routine Physicals: 13 visits ages 0-36 months, annuallyages 3-21, 1 per 4
	Routine Physicals	No charge	30% co-insurance	years ages 22-34,1 per 2 years ages 35-59, and annuallyage 60+. WellWoman
	Well Baby/Child Visit	No charge	30% co-insurance Not covered	Visits:annually. Tobacco Cessation: 2 quit attempts in lifetime. Immunizations:CDC
	Well Woman Visit	No charge	30% co-insurance	Recommended.
	Tobacco Cessation	No	50% co-insurance	
	Immunizations			
If you have a test	Diagnostic test (x-ray, blood work)	No charge for 1st $400, then 30% co-insurance	50% co-insurance	Deductible waived for first $400 at participating providers.
	Imaging (CT/PET scans, MRIs)	$100 co-pay/test	$100 co-pay/test plus 50% co-	Pre-authorization required; no coverage if not pre-authorized.

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at PacificSource.com	Generic drugs	Retail: $10 co-pay Mail: $30 co-pay	Not covered (except 5-day emergency supply)	Retail limited to 30-day supply. Mail limited to 90-day supply. Pre-authorization required for certain drugs.
	Preferred brand drugs	Retail: $50 co-pay Mail: $150 co-pay	Not covered (except 5-day emergency supply)	See Generic drugs above
	Non-preferred brand drugs	Retail: $75 co-pay Mail: $225 co-pay	Not covered (except 5-day emergency supply)	See Generic drugs above
	Specialty drugs	$100 or 20%	Not covered (except 5-day emergency supply)	Coverage available only through our specialty pharmacy services provider. Limited to 30-day supply. Pre-authorization required for certain drugs.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% co-insurance	50% co-insurance	---none---
	Physician/surgeon fees	30% co-insurance	50% co-insurance	---none---
If you need immediate medical attention	Emergency room services	$250 co-pay/visit plus 30% co-insurance	$250 co-pay/visit plus 50% co-insurance	Co-pay waived if admitted. Non-participating paid as participating if emergency medical condition.
	Emergency medical transportation Ground Ambulance	30% co-insurance	30% co-insurance	Limited to nearest facility able to treat condition. Air covered if ground medically or physically inappropriate.
	Air Ambulance	50% co-insurance	50% co-insurance	

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
				Non-participatingair covered up to Medicare allowance.
	Urgent care	$35 co-pay/visit	$35 co-pay/visit plus 30% co-	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	30% co-insurance	50% co-insurance	Limited to semi-private room unless intensiveor coronary care units, medically necessaryisolation, or hospital only has private rooms. Pre-authorizationrequired for inpatient electivesurgery.
	Physician/surgeon fee	30% co-insurance	50% co-insurance	---none---
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$35 co-pay/visit	$35 co-pay/visit plus 30% co-insurance	---none---
	Mental/Behavioral health inpatient services	30% co-insurance	50% co-insurance	Small Employer Group:Long-term residential programs limited to 45 Must be pre-authorized.
	Substance use disorder outpatient services	$35 co-pay/visit	$35 co-pay/visit plus 30% co-insurance	---none---
	Substance use disorder inpatient services	30% co-insurance	50% co-insurance	Small Employer Group:Long-term residential programs limited to 45 Must be pre-authorized.
If you are pregnant	Prenatal and postnatal care	30% co-insurance	50% co-insurance	---none---
	Delivery and all inpatient services	30% co-insurance	50% co-insurance	Practitioner deliveryand hospital visits arecovered under prenatal and postnatal care. Facilityis covered the same as any otherhospital services.
	Home health care	30% co-insurance	50% co-insurance	No coverage for privateduty nursing. Pre-authorization required.
If you need help recovering or have	Rehabilitation services: Inpatient	30% co-insurance	50% co-insurance	Inpatient: Limited to 30 days/condition; 60days if head or spinalcord injury. Pre-authorization required.

Common Medical Event	Services You May Need		Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
special health needs		Outpatient	30% co-insurance	40% co-insurance	Outpatient: Limited to 30 visits/year; up to 30 additional visits if neurological condition. No coverage for recreation therapy.
	Habilitation services:	Inpatient	30% co-insurance	50% co-insurance	Inpatient: Limited to 30 days/condition; 60 days if head or spinal cord injury. Pre-authorization required.
		Outpatient	30% co-insurance	40% co-insurance	Outpatient: Limited to 30 visits/year; up to 30 additional visits if neurological condition. No coverage for recreation therapy.
	Skilled nursing care		30% co-insurance	50% co-insurance	Limited to 60 days/year. No coverage for custodial care. Pre-authorization required.
	Durable medical equipment		30% co-insurance	50% co-insurance	Limited to: $5,000/year overall; one/lifetime age 19+ for power-assisted wheelchairs; $200 for glasses or contact lenses to correct a specific vision defect from a severe medical or surgical problem; $4,000 per 48 months for hearing aid age 0-18 (or age 0-25 if student); no coverage for adult hearing aids; and $150/year for wig for chemotherapy or radiation
	Hospice service		30% co-insurance	50% co-insurance	
If your child needs dental or eye care	Eye Exam		Not Covered	Not Covered	Not Covered
	Glasses		Not Covered	Not Covered	Not Covered
	Dental Check-up		Not Covered	Not Covered	Not Covered

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Naturopath
- Massage Therapy
- Glasses (Child)
- Dental Check-up(Child)
- Bariatric Surgery
- Vision Exam (Child)
- Acupuncture
- Chiropractic Care
- Cosmetic Surgery
- Dental Care (Adult)
- Infertility Treatment
- Hearing Aids (Adult)
- Long Term Care
- Non-emergency care when traveling outside the US
- Private Duty Nursing
- Routine eye care (Adult)
- Routine foot care, other than with diabetes mellitus
- Custodial Care
- Recreational Therapy

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Weight Loss Programs
- ☐ Hearing Aids (Child)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-888-977-9299. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact the PacificSource Customer Service Department at 1-888-977-9299. For group health coverage subject to ERISA, you can also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact the Oregon Insurance Division's Consumer Advocacy Unit at 1-503-947-7984 or toll-free at 1-888-877-4894.

Language Access Services:

Spanish (Espanol): Para obtener asistencia en Espanol, llame al 1-888-977-9299

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

• **Amount owed to providers:**	$7540
• **Plan pays**	$3390
• **Patient pays**	$4150

Sample care costs:

Hospital charges (mother)	$2700
Routine obstetric care	$2100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	$7540

Patient pays:

Deductibles	$3000
Co-pays	$20
Co-insurance	$1100
Limits or exclusions	$30
Total	$4150

Managing type 2 diabetes
(routine maintenance of a well controlled condition)

• **Amount owed to providers:**	$5400
• **Plan pays:**	$3360
• **Patient pays:**	$2040

Sample care costs:

Prescriptions	$2900
Medical Equipment and Supplies	$1300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	$5400

Patient pays:

Deductibles	$1300
Co-pays	$700
Co-insurance	$0
Limits or exclusions	$40
Total	$2040

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact; 1-888-977-9299.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs wouldhave been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, Co-payments, and co-insurance can add up.It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

No. Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

☐☐☐ Yes. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays' box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

☐☐☐ Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as co-payments, deductibles, and co-insurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.