

Medical, Vision and Prescription coverage provided by PacificSource Health Plans

Medical: PacificSource Preferred Provider Option (PPO) plan. **To receive maximum benefits, it is important to use In-Network PPO providers.** In-Network benefits include an annual deductible of \$150 per person, or \$300 for family coverage, with an annual out-of-pocket maximum of \$1000 per person. In-Network office visits have a \$20 co-payment. Out-of-Network benefits include an annual deductible of \$300 per person, or \$600 for family coverage, with an annual out-of-pocket maximum of \$1500 per person. Out-of-Network office visits are charged at 40% after deductible. A list of in-network providers included in the Preferred PSN plan can be accessed online at www.pacificsource.com.

Vision: In-Network benefits include one eye exam every calendar year paid at 100%. Out-of-Network benefits include one eye exam every calendar year paid at 100%, up to a maximum of \$64.50.

Dental Coverage Provided by Oregon Dental Service (ODS) or Willamette Dental

ODS Coverage: Preventative services are paid at 100%; restorative services are paid at 80% after a \$25 deductible; major services are paid at 60% after a \$25 deductible. Annual maximum benefit is \$2000 in paid benefits (by ODS) per member per calendar year. No orthodontia coverage. This coverage is administered through OEA Choice Trust.

Willamette Dental Coverage: Preventative, restorative and major services are paid at 100% after a \$10 office visit co-payment. No annual maximum benefit applies. Orthodontia coverage is paid at 100% after a one-time \$1500 orthodontia co-payment and a \$10 office co-payment per visit.

Monthly Contribution Summary for Medical, Vision and Dental Insurance

Employee pre-tax payroll deduction for PacificSource Medical, Vision & Rx with		
<u>Coverage Level</u>	<u>ODS Dental</u>	<u>Willamette Dental</u>
Employee Only Coverage	\$8.63	\$0.00
Employee + 1 Coverage	\$121.34	\$98.08
Full Family Coverage	\$154.93	\$117.14

Employer contribution for PacificSource Medical, Vision & Rx with		
<u>Coverage Level</u>	<u>ODS Dental</u>	<u>Willamette Dental</u>
Employee Only Coverage	\$593.44	\$589.89
Employee + 1 Coverage	\$1241.36	\$1241.36
Full Family Coverage	\$1557.29	\$1557.29

Carrier Contact Information

- PacificSource.....(541) 684-5582 (888) 977-9299
- Oregon Dental Service.....(503) 265-2965 (888) 217-2365
- Willamette Dental.....(800) 460-7644 customer service..... (800) 461-8994 appointments
- OEA Choice Trust.....(503) 620-3822 (800) 452-0914

Benefit Plan Summary

This is a brief summary of benefits. Please refer to your specific Member Handbook for complete details. Plan benefits are governed by the terms of the group policy, which alone determines benefit payments.

Medical Insurance

PacificSource Preferred PSN Plan	In-Network Provider Benefit	Out-of-Network Provider Benefit
Lifetime maximum benefit	\$2,000,000	
Individual deductible per calendar year	\$150*	\$300*
Family deductible per calendar year	\$300*	\$600*
Individual out-of-pocket maximum per calendar year	\$1,000*	\$1,500*
Family out-of-pocket maximum per calendar year	\$2,000*	\$3,000*
After the out-of-pocket maximum is met each calendar year, the plan pays	100%	100%
Preventative Care Services and Office Visits	Deductible Waived The Plan Pays	After Deductible The Plan Pays
Office visit co-payment	\$20	60%
Immunizations all ages (subject to preventative care schedule)	100%	Not Covered
Well-baby care (subject to preventative care schedule)	100% after co-pay	Not Covered
Routine physical exam (subject to preventative care schedule)	100% after co-pay	Not Covered
Annual women's exam including pap test and mammogram	100% after co-pay	60%
Office visit	100% after co-pay	60%
Urgent care centers	100% after co-pay	60%
Outpatient mental health/chemical dependency**	100% after co-pay	60%
Facility Benefits	After Deductible - The Plan Pays	
Hospital		
Inpatient care	80%	60%
Inpatient rehabilitation	80%	60%
Nursery care	80%	60%
Inpatient mental health/chemical dependency**	80%	60%
Skilled nursing facility (up to 60 days per calendar year)	80%	60%
Emergency room co-payment (waived if admitted)	\$100	\$100
Emergency room care (co-pay waived if admitted)	80% after co-pay	60% after co-pay
Hospital call	80%	60%
Other Services	After Deductible - The Plan Pays	
Diagnostic radiology and lab	80%	60%
Therapeutic injections including allergy shots	80%	60%
Outpatient surgery (requires pre-authorization)	80%	60%
Hearing aid (maximum of \$800 every 3 years)	80%	60%
Hospice (plan limits may apply)	80%	60%
Home health care (plan limits may apply)	80%	60%
Surgery	80%	60%
Anesthesiologist	80%	60%
Ambulance (including ground and air)	80%	80%
Outpatient rehabilitation (plan limits may apply)	80%	60%
TMJ treatment (\$3000 lifetime maximum)	80%	60%
Outpatient durable medical equipment and supplies	80%	60%
Family Planning	After Deductible - The Plan Pays	
Female Sterilization	80%	60%
Male Sterilization	80%	60%
Infertility (limited benefit)	50%	50%
Alternative Care	After Deductible - The Plan Pays	
Chiropractor (24 visits per calendar year)	80%	80%
Massage therapy, naturopaths, acupuncture (24 visits per calendar year)	80%	80%

Prescription Medications	No Deductible - You Pay	
Medications purchased from a pharmacy (maximum quantity 34-day supply)	\$20 co-pay or 20%, whichever is greater	Eligible prescription drugs will be reimbursed at the pharmacy contracted rate, minus the plan co-pay -OR- the UC&R charge minus the plan co-pay, whichever is less
Medications purchased from Mail Order service (90-day supply)	\$20 co-pay	
Individual out-of-pocket maximum per calendar year	\$750 (separate from medical)	

* Expenses applied toward the annual deductible do not apply to the out-of-pocket maximum.

** Subject to state-mandated limitations.

*** All services are subject to the plan's maximum plan allowance for those services.

Preventative Care Schedule	
Child	
Age 0-2	Routine newborn care in the nursery plus 8 visits anytime during the first 2 years
Age 2-6	Every year
Age 7-18	Every 2 years
Adult	
Age 19-34	Every 4 years
Age 35+	Every 2 years
Women	
Age 18+	Annual exam including pap smear and pelvic exam
Age 35-39	Mammogram once during this time
Age 40+	One mammogram per year
Immunizations all ages	Per physician
Eye/Hearing exam through age 18	Every 2 years

Mental Illness/Chemical Dependency (including alcoholism) Subject to State Mandates	Adult Benefit (during any 2 calendar year period)	Child Benefit (during any 2 calendar year period)
Mental Health*		
Residential	19 days	21 days
Inpatient	16 days	17 days
Chemical Dependency*		
Residential	21 days	30 days
Inpatient	14 days	32 days

* Must be pre-authorized and referred by the PacificSource Mental Health/Chemical Dependency Program Coordinator.

Vision Insurance

PacificSource Preferred PSN Plan	In-Network Provider Benefit	Out-of-Network Provider Benefit
Examination (one per calendar year)	100%	100% up to \$64.50
Lenses (one pair every calendar year)		
Single vision lenses	100% up to \$105	
Bifocal lenses	100% up to \$130	
Trifocal lenses	100% up to \$150	
Frames (one pair every two calendar years)	100% up to \$125	
Contact Lens (one pair per calendar year)		
Necessary after cataract surgery	100%	
Only means to correct vision to 20/70 or better	100%	
Alternative to frames and lenses	100% up to the total cost of single vision lenses and a frame	

Dental Insurance Plan Options

Dental Benefits	OEA Oregon Dental Service	Willamette Dental
Office Visit	No charge	\$10
Annual Benefit Maximum	\$2,000	None
Deductible	\$25/member; \$75/family	None
Preventive and Diagnostic Services - Class I		
Oral exams, X-rays, cleaning (prophylaxis), fluoride treatments, and space maintainers	100%	100%*
Restorative Services - Class II		
Routine fillings	80% after deductible met ¹	100%* ²
Simple Tooth Extractions	80% after deductible met	100%*
Surgical tooth extractions, including diagnosis and evaluation	80% after deductible met	100%*
Diagnosis, evaluation, and treatment of gum disease including scaling and root planing	80% after deductible met	100%*
Root canal and related therapy including diagnosis and evaluation	80% after deductible met	100%*
Major Restorative Services - Class III		
Gold or porcelain crowns	60% after deductible met ¹	100%*
Full and partial dentures	60% after deductible met	100%*
Bridge retainers and pontics	60% after deductible met	100%*
Orthodontics	Not covered	\$1,500 copay + \$10 per visit**

Under ODS plans, services are available through any dentist, whereas Willamette Dental members must see Willamette Dental providers.

***For the Willamette Dental plan, services rendered plus the office visit fee copay per visit**

**** Pre-Orthodontic Service fee of \$150 is credited towards the orthodontic benefit if patient accepts treatment plan**

¹ Posterior fillings and crowns paid to standard materials fees

² Fillings are covered at 100% for all amalgam tooth surfaces, composite anteriors and 1 surface composite posteriors. Patients can request composite fillings, which are considered a buy-up and additional fees apply. Please contact Willamette directly for actual fees.

Underwritten by Oregon Dental Service

This plan provides extensive coverage of services and supplies to prevent, diagnose and treat diseases or conditions of the teeth and supporting tissues. Presented are just some of the most common procedures covered in your plan. This is a summary only. Please see the Certificate of Coverage for a complete plan description, limitations, and exclusions.