

**Medical and Vision Benefits**

This is a brief summary of the medical and vision benefits provided under PacificSource Health Plans Preferred PSN plan for LCC employees and their dependents. Plan benefits are governed by the terms of the group policy, which alone determines benefit payments. Please refer to your specific Member Handbook for complete details.

Plan Benefits	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 your out-of-pocket maximum is met each calendar year, the plan pays	100%	100%
<b>Preventative Care Services and Office Visits</b>	<b>Deductible Waived The Plan Pays</b>	<b>After Deductible The Plan Pays</b>
Immunizations all ages (subject to preventative care schedule)	100%	Not Covered
Well-baby care (subject to preventative care schedule)	100% after \$20 co-pay	Not Covered
Routine physical exam (subject to preventative care schedule)	100% after \$20 co-pay	Not Covered
Annual women's exam including pap test and mammogram	100% after \$20 co-pay	60%
Office visit	100% after \$20 co-pay	60%
Urgent care centers	100% after \$20 co-pay	60%
Outpatient mental health/chemical dependency**	100% after \$20 co-pay	60%
<b>Facility Benefits</b>	<b>After Deductible - The Plan Pays</b>	
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 care (co-pay waived if admitted)	80% after \$100 co-pay	60% after \$100 co-pay
Hospital call	80%	60%
<b>Other Services</b>	<b>After Deductible - The Plan Pays</b>	
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%
<b>Family Planning</b>	<b>After Deductible - The Plan Pays</b>	
Female Sterilization	80%	60%
Male Sterilization	80%	60%
Infertility (limited benefit)	50%	50%
<b>Alternative Care</b>	<b>After Deductible - The Plan Pays</b>	
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 <b>-OR-</b> the UC&R charge minus the plan co-pay, whichever is less
Medications purchased from Walgreens 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 Maximum (during any 2 calendar year period)	Child Benefit Maximum (during any 2 calendar year period)
Mental Health*		
Outpatient	36 visits	36 visits
Residential	19 days	21 days
Inpatient	16 days	17 days
Chemical Dependency*		
Outpatient	32 visits	42 visits
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 Benefit Features	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, subject to maximum allowance)		
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, subject to limitations)		
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	

Questions? Contact PacificSource Health Plans Customer Service at (541) 684-5582 or (888) 977-9299.  
www.pacificsource.com

## Dental Benefits

This is a brief summary of the dental benefits provided under OEA Choice Trust/Oregon Dental Service for LCC employees and their dependents. Plan benefits are governed by the terms of the group policy, which alone determines benefit payments. Please refer to your specific Member Handbook for complete details. The dental plan provides coverage for services provided by participating and non-participating dental providers as listed below. Under this plan, participating providers will not charge more than the contracted fees. Non-participating providers will bill for the balances that exceed the contracted fees.

Benefit Features	
Maximum benefit per person per calendar year	\$2,000
Individual deductible per calendar year	\$25
Family deductible per calendar year	\$75
Class I Dental Services	
Deductible Waived - The Plan Pays	
Preventative Services (subject to preventative services schedule)	
Examination	100%
Cleaning	100%
X-rays	100%
Fluoride treatment	100%
Fissure sealant	100%
Class II Dental Services	
After Deductible - The Plan Pays	
Restorative Services	
Fillings	80%
Simple extractions	80%
Periodontics	80%
Oral Surgery	80%
Endodontics	80%
Class III Dental Services	
After Deductible - The Plan Pays	
Major Services	
Crowns	60%
Bridges	60%
Dentures	60%
Cast Restoration	60%

Preventative Services Schedule	
Oral examination	Every 6 months
Cleaning	Every 6 months
X-rays	
Full Mouth	Every 3 years
Bitewing	Every 6 months
Fluoride treatment	Every 6 months
Fissure sealant (limits and exclusions apply)	Every 5 years

*Questions? Contact ODS at (503) 265-5680 or (877) 277-7280.*

*[www.oeachoice.com](http://www.oeachoice.com)*