PacificSource HEALTH PLANS

Medical Benefit Summary
Voyager 100_20+Rx S3

Marion County MCLEA

Provider Network: **Voyager**

Deductible Per Calendar Year	In-network and Out-of-network	
Individual/Family	$100/$300	
Out-of-Pocket Limit Per Calendar Year	**In-network**	**Out-of-network**
Individual/Family	$800/$13,200	$1,600/Not applicable

Note: Your actual costs for services provided by an out-of-network provider may exceed this plan's out-of-pocket limit for out-of-network services. In addition, out-of-network providers can bill you for the difference between the amount charged by the provider and the amount allowed by the insurance company, and this amount is not counted toward the out-of-network out-of-pocket limit. Please see allowable fee in the Definitions section of your member handbook.

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, 40%
Preventive physicals	No deductible, 0%	After deductible, 40%
Well woman visits	No deductible, 0%	After deductible, 40%
Preventive mammograms	No deductible, 0%	After deductible, 40%
Immunizations	No deductible, 0%	After deductible, 40%
Preventive colonoscopy	No deductible, 0%	After deductible, 40%
Prostate cancer screening	No deductible, 0%	After deductible, 40%
Professional Services		
Office and home visits	After deductible, 20%	After deductible, 40%
Naturopath office visits	After deductible, 20%	After deductible, 40%
Specialist office and home visits	After deductible, 20%	After deductible, 40%
Telemedicine visits	After deductible, 20%	After deductible, 40%
Office procedures and supplies	After deductible, 20%	After deductible, 40%
Surgery	After deductible, 20%	After deductible, 40%
Outpatient rehabilitation and habilitation services	After deductible, 20%	After deductible, 40%
Chiropractic manipulations and acupuncture ($1,000 per benefit year)	No deductible, 20%	No deductible, 20%

Service/Supply	In-network Member Pays	Out-of-network Member Pays
Hospital Services		
Inpatient room and board	After deductible, $100/admit plus 20%	After deductible, $100/admit plus 40%
Inpatient rehabilitation and habilitation services	After deductible, $100/admit plus 20%	After deductible, $100/admit plus 40%
Skilled nursing facility care	After deductible, $100/admit plus 20%	After deductible, $100/admit plus 40%
Outpatient Services		
Outpatient medical surgery/services	After deductible, 20%	After deductible, 40%
Outpatient dental surgery/services	After deductible, $100 plus 20%	After deductible, $100 plus 40%
Outpatient at ambulatory surgery center	After deductible, 10%	After deductible, 40%
Advanced diagnostic imaging	After deductible, 20%	After deductible, 40%
Diagnostic and therapeutic radiology/lab and dialysis	No deductible, 20%	After deductible, 40%
Urgent and Emergency Services		
Urgent care center visits	No deductible, 20%	No deductible, 20%
Emergency room visits – medical emergency	No deductible, $100 plus 20%^	No deductible, $100 plus 20%^
Emergency room visits – non-emergency	No deductible, $100 plus 20%^	No deductible, $100 plus 20%^
Ambulance, ground	After deductible, 20%	After deductible, 20%
Ambulance, air	After deductible, 20%	After deductible, 20%+
Maternity Services**		
Physician/Provider services (global charge)	After deductible, 20%	After deductible, 40%
Hospital/Facility services	After deductible, $100/admit plus 20%	After deductible, $100/admit plus 40%
Mental Health and Substance Use Disorder Services		
Office visits	After deductible, 20%	After deductible, 40%
Inpatient care	After deductible, $100/admit plus 20%	After deductible, $100/admit plus 40%
Residential programs	After deductible, $100/admit plus 20%	After deductible, $100/admit plus 40%
Other Covered Services		
Allergy injections	After deductible, 20%	After deductible, 40%
Durable medical equipment	After deductible, 20%	After deductible, 40%
Home health services	After deductible, 20%	After deductible, 40%
Transplants	After deductible, $100/admit plus 20%	After deductible, $100/admit plus 40%

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

^ Co-pay applies to ER physician and facility charges only. Co-pay 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, 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 member 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. Deductible expense is applied to the out-of-pocket limit.

In-network provider expense and out-of-network provider 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 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 when it comes to meeting your out-of-pocket limit. Only in-network expense applies to the in-network out-of-pocket limit Only out-of-network expense applies to the out-of-network out-of-pocket limit.

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.

PacificSource HEALTH PLANS

Prescription Drug Benefit Summary
OR 25P S4 PDL

Marion County MCLEA

Formulary: Preferred Drug List (PDL)

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.

Medical Deductible

You must meet the medical deductible, which is shown on the Medical Benefit Summary, before your prescription drug benefits begin.

PacificSource Expanded (Preventive) No-cost Drug List and Affordable Care Act Standard Preventive No-cost Drug List

Your prescription benefit includes certain outpatient drugs as a preventive benefit at 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. You can get a list of covered preventive drugs by contacting our Customer Service team or visit PacificSource.com/drug-list.

Each time a covered prescription is dispensed, you are responsible for any amounts shown above, in addition to the following amounts:

Service/ Supply	Incentive Drugs:	Tier 1 Member Pays	Tier 2 Member Pays	Tier 3 Member Pays
In-network Retail Pharmacy				
Up to a 90 day supply:	No deductible, 0%	After deductible, 25%	After deductible, 25%	After deductible, 25%
In-network Mail Order Pharmacy				
Up to a 90 day supply:	No deductible, 0%	After deductible, 25%	After deductible, 25%	After deductible, 25%
Compound Drugs**				
Up to a 90 day supply:	After deductible, 25%			
Out-of-network Pharmacy				
30 day max fill, no more than three fills allowed per year:	After deductible, 25%			

	Tier 1, Tier 2, and Tier 3 Member Pays
Specialty Drugs – In-network Specialty Pharmacy	
Up to a 30 day supply:	After deductible, 25%
Specialty Drugs – Out-of-network Specialty Pharmacy	
30 day max fill, no more than three fills allowed per year:	After deductible, 25%

**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.

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 after the medical deductible is met. The cost difference between the brand name and generic drug does not apply toward the medical plan's deductible or out-of-pocket limit. Does not apply to 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.

PacificSource HEALTH PLANS

Vision Benefit Summary
Vision Plus S3

Marion County MCLEA

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	In-network Member Pays	Out-of-network Member Pays
Enrolled Members Age 18 and Younger		
Eye exam	No deductible, 0%	No deductible, 0% up to $45 then 100%
Vision hardware	No deductible, 0% for one pair per year for frames and/or lenses	No deductible, 0% for one pair per year up to $75 then 100% for frames and/or lenses
Enrolled Members Age 19 and Older		
Eye exam	No deductible, 0%	No deductible, 0% up to $45 then 100%
Single vision lenses	No deductible, 0%	No deductible, 0% up to $30 then 100%
Bifocal lenses	No deductible, 0%	No deductible, 0% up to $50 then 100%
Trifocal lenses	No deductible, 0%	No deductible, 0% up to $65 then 100%
Lenticular lenses	No deductible, 0%	No deductible, 0% up to $100 then 100%
Progressive lenses	No deductible, 0%	No deductible, 0% up to $50 then 100%
Frames	No deductible, 0% up to $200 then 100%	No deductible, 0% up to $70 then 100%
Contact lenses	No deductible, 0% up to $200 then 100%	No deductible, 0% up to $105 then 100%

Benefit Limitations: enrolled members age 18 and younger

- One vision exam every calendar year.
- Vision hardware includes glasses (lenses and frames) or contacts (lenses and fitting) once per calendar year.

Benefit Limitations: enrolled members age 19 and older

- One vision exam every calendar year.
- Lenses: One pair every two calendar years.

- Frames: Once every two calendar years.
- Contact lenses: Once every two calendar years.
- Elective contact lenses are in lieu of frames and lenses.
- Anti-reflective coatings and scratch resistant coatings are covered.

Exclusions

- Charges for services or supplies covered in whole or in part under any medical or vision benefits provided by an employer.
- Duplication of spare eyeglasses or any lenses or frames for members age 18 and younger.
- Expenses covered under any workers' 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.
- Replacement of lost, stolen, or broken lenses or frames.
- 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.
- Special supplies, such as sunglasses and subnormal vision aids.
- 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: 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 maximum benefit. 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 benefits cannot be combined with any other discounts or coupons. You can use your plan's in-network

benefits, or you can use your plan’s out-of-network 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 benefits.