PacificSource HEALTH PLANS

Oregon State University - GSE

Medical Benefit Summary
Navigator 100_10 S4

Benefit Year: Contract Year

Provider Network: Navigator

Deductible Per Benefit Year	In-network and Out-of-network	
Individual/Family	$100/$300	
Out-of-Pocket Limit Per Benefit Year	**In-network**	**Out-of-network**
Individual/Family	$1,000/$12,700	$3,000/Not applicable

Note: In-network out-of-pocket limit accumulates separately from the out-of-network out-of-pocket limit. Even though you may have the same benefit for in-network and out-of-network, your actual costs for services provided out-of-network may exceed this plan's out-of-pocket limit for out-of-network services. In addition, out-of-network providers may in certain circumstances bill you for the difference between the amount charged by the provider and the amount allowed by the insurance company (called balance billing). Balance billing amounts are not counted toward the out-of-network out-of-pocket limit. For additional information about balance billing or allowable fees, see your 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, 30%
Preventive physicals	No deductible, 0%	After deductible, 30%
Well woman visits	No deductible, 0%	After deductible, 30%
Preventive mammograms	No deductible, 0%	After deductible, 30%
Immunizations	No deductible, 0%	After deductible, 30%
Preventive colonoscopy	No deductible, 0%	After deductible, 30%
Prostate cancer screening	No deductible, 0%	After deductible, 30%
Professional Services		
Office and home visits	First three visits no deductible, 0%. Subsequent visits, after deductible, 10%*	After deductible, 30%

Service/Supply	In-network Member Pays	Out-of-network Member Pays
Naturopath office visits	After deductible, 10%	After deductible, 30%
Specialist office and home visits	After deductible, 10%	After deductible, 30%
Telehealth visits	First three visits no deductible, 0%. Subsequent visits, after deductible, 10%*	After deductible, 30%
Office procedures and supplies	After deductible, 10%	After deductible, 30%
Surgery	After deductible, 10%	After deductible, 30%
Outpatient rehabilitation and habilitation services	After deductible, 10%	After deductible, 30%
Acupuncture (12 visits per benefit year)	After deductible, 10%	After deductible, 30%
Chiropractic manipulation/Spinal manipulation (20 visits per benefit year)	After deductible, 10%	After deductible, 30%
Hospital Services		
Inpatient room and board	After deductible, 10%	After deductible, 30%
Inpatient rehabilitation and habilitation services	After deductible, 10%	After deductible, 30%
Skilled nursing facility care	After deductible, 10%	After deductible, 30%
Outpatient Services		
Outpatient surgery/services	After deductible, 10%	After deductible, 30%
Diagnostic imaging – advanced	After deductible, 10%	After deductible, 30%
Diagnostic and therapeutic radiology/laboratory and dialysis – non-advanced	After deductible, 10%	After deductible, 30%
Urgent and Emergency Services		
Urgent care center visits	After deductible, 10%	After deductible, 30%
Emergency room visits – medical emergency	After deductible, $50 plus 10%^	After deductible, $50 plus 10%^
Emergency room visits – non-emergency	After deductible, $50 plus 10%^	After deductible, $50 plus 30%^
Ambulance, ground	After deductible, 20%	After deductible, 20%
Ambulance, air	After deductible, 50%	After deductible, 50%

Service/Supply	In-network Member Pays	Out-of-network Member Pays
Maternity Services**		
Physician/Provider services (global charge)	After deductible, 10%	After deductible, 30%
Hospital/Facility services	After deductible, 10%	After deductible, 30%
Mental Health and Substance Use Disorder Services		
Office visits	First three visits no deductible, 0%. Subsequent visits, after deductible, 10%*	After deductible, 30%
Inpatient care	After deductible, 10%	After deductible, 30%
Residential programs	After deductible, 10%	After deductible, 30%
Other Covered Services		
Allergy injections	After deductible, 10%	After deductible, 30%
Durable medical equipment	After deductible, 10%	After deductible, 30%
Home health services	After deductible, 10%	After deductible, 30%
Transplants	After deductible, 0%	After deductible, 30%

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

^ Copay waived if admitted into hospital.

*First 3 visits per benefit year combined for Professional Services – Office and home visits, Telehealth visits, and Mental Health and Substance Use Disorder Services – Office visits.

** Medically necessary services, medication, and supplies to manage diabetes during pregnancy from conception through six weeks postpartum will not be subject to a deductible, copayment, or coinsurance.

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.

In-network expense and out-of-network 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 services during the benefit 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 benefit 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 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.

Payments to providers

Payment to providers is based on the prevailing or allowable fee for covered services. In-network providers accept the allowable fee as payment in full. Services of out-of-network providers could result in out-of-pocket expense in addition to the percentage indicated.

Prior authorization

Coverage of certain medical services and surgical procedures requires a benefit determination by PacificSource before the services are performed. This process is called prior authorization. Prior authorization is necessary to determine if certain services and supplies are covered under this plan, and if you meet the plan's eligibility requirements. Prior authorization does not change your out-of-pocket expense for in-network and out-of-network providers. You can search for procedures and services that require prior authorization on our website, Authgrid.PacificSource.com (select Commercial for the line of business).

Discrimination is against the law

PacificSource Health Plans complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. PacificSource does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

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Prescription Drug Benefit Summary
OR 15-25-35 S2 ODL

Benefit Year: Contract Year

Formulary: Oregon Drug List (ODL)

This 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/find-a-drug.

The amount you pay for covered prescriptions at in-network pharmacies applies toward your plan's in-network medical out-of-pocket limit, the amount you pay for covered prescriptions at out-of-network pharmacies applies toward your plan's out-of-network out-of-pocket limit which is shown on the Medical Benefit Summary. The copayment and/or coinsurance for prescription drugs obtained from an in-network or out-of-network pharmacy are waived during the remainder of the benefit year in which you have satisfied the medical out-of-pocket limit.

Affordable Care Act Standard Preventive No-cost Drug List

Your prescription benefit includes preventive care drugs at no cost to you and are not subject to a deductible or MAC penalties. This benefit includes some drugs required by the Affordable Care Act, including tobacco cessation drugs. These drugs are identified on the drug list as Tier 0.

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

Service/ Supply	Tier 1 Member Pays	Tier 2 Member Pays	Tier 3 Member Pays	Tier 4 Member Pays
In-network Retail Pharmacy				
Up to a 30 day supply:	No deductible, $15	No deductible, $25*	No deductible, $35*	No deductible, $35
31 - 60 day supply:	No deductible, $30	No deductible, $50	No deductible, $70	No deductible, $70
61 - 90 day supply:	No deductible, $45	No deductible, $75	No deductible, $105	No deductible, $105
In-network Mail Order Pharmacy				
Up to a 30 day supply:	No deductible, $15	No deductible, $25*	No deductible, $35*	No deductible, $35
31 - 60 day supply:	No deductible, $30	No deductible, $50	No deductible, $70	No deductible, $70
61 - 90 day supply:	No deductible, $45	No deductible, $75	No deductible, $105	No deductible, $105

Service/ Supply	Tier 1 Member Pays	Tier 2 Member Pays	Tier 3 Member Pays	Tier 4 Member Pays
Compound Drugs**				
Up to a 30 day supply:	No deductible, $35			
31 - 60 day supply:	No deductible, $70			
61 - 90 day supply:	No deductible, $105			
Out-of-network Pharmacy				
30 day maximum fill, no more than three fills allowed per year:	Same as retail			

*Formulary prescription insulin will not be subject to a deductible and limited to $85 copay per 30 day supply.

**Compounded medications are subject to a prior authorization 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 B - Unless the prescribing provider requires the use of a brand name drug, the prescription will automatically be filled with a generic drug when available and permissible by state law. If you receive a brand name drug when a generic is available, you will be responsible for the brand name drug's copayment and/or coinsurance plus the difference in cost between the brand name drug and its generic equivalent. If your prescribing provider requires the use of a brand name drug, the prescription will be filled with the brand name drug and you will be responsible for the brand name drug's copayment and/or coinsurance. The cost difference between the brand name and generic drug does not apply toward the medical out-of-pocket limit. Does not apply to preventive bowel prep kits covered under USPSTF guidelines.

If your provider prescribes a brand name contraceptive due to medical necessity it may be subject to prior authorization for coverage at no charge.

See your handbook for important information about your prescription drug benefit, including which drugs are covered, limitations, and more.

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Vision Benefit Summary
Vision 0-350 S2

Benefit Year: Contract Year

The following shows the vision benefits available under this plan 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 member turns 19. Copayment and/or coinsurance for covered charges apply to the medical plan's out-of-pocket limit.

Service/Supply	In-network Member Pays	Out-of-network Member Pays
Members Age 18 and Younger		
Eye exam	No deductible, $0	No deductible up to $40 then 100%
Vision hardware	No deductible, 0% for one pair per year for frames or lenses	No deductible, 0% for one pair per year up to $75 then 100% for frames and/or lenses
Members Age 19 and Older		
Eye exam	No deductible, $0	No deductible up to $40 then 100%
Vision hardware	No deductible, 0% up to $350	

Benefit Limitations: members age 18 and younger

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

Benefit Limitations: members age 19 and older

- One vision exam every benefit year.
- Vision hardware includes glasses (lenses and frames) and/or contacts (lenses and fitting). Benefit maximum is per benefit year.
- 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.
- 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.

- Services or supplies not listed as covered services.
- 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 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 copayments 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.

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Dental Benefit Summary
Dental Choice Plus 0-20-50 50-2500 S3

Benefit Year: Contract Year

This plan covers the following services when performed by a provider to the extent that they are operating within the scope of their license as required under law in the state of issuance, and when determined to be necessary, usual, and customary by the standards of generally accepted dental practice for the prevention or treatment of oral disease or for accidental injury, including masticatory function (chewing of food).

Deductible Per Benefit Year	All Providers
Individual/Family	$50 / $150
Benefit Maximum Per Benefit Year	
$2,500 per individual. Applies to all covered services.	
Exclusion Period	**Number of Consecutive Months**
Class II Services	None
Class III Services	None

The member is responsible for any amounts shown above, in addition to the following amounts:

Service/Supply	All Providers Member Pays
Class I Services	
Examinations	No deductible, 0%
Bitewing films, full mouth x-rays, cone beam x-rays, and/or panorex	No deductible, 0%
Dental cleaning (prophylaxis and periodontal maintenance)	No deductible, 0%
Fluoride (topical or varnish applications)	No deductible, 0%
Sealants	No deductible, 0%
Space maintainers	No deductible, 0%
Athletic mouth guards	No deductible, 0%
Brush biopsies	No deductible, 0%

Service/Supply	All Providers Member Pays
Class II Services	
Fillings	After deductible, 20%
Simple extractions	After deductible, 20%
Periodontal scaling and root planing	After deductible, 20%
Full mouth debridement	After deductible, 20%
Complicated oral surgery	After deductible, 20%
Pulp capping	After deductible, 20%
Pulpotomy	After deductible, 20%
Root canal therapy	After deductible, 20%
Periodontal surgery	After deductible, 20%
Tooth desensitization	After deductible, 20%
Class III Services	
Crowns	After deductible, 50%
Dentures	After deductible, 50%
Bridges	After deductible, 50%
Replacement of existing prosthetic device	After deductible, 50%

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Additional information

What is the deductible?

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What is the benefit maximum?

The benefit maximum is the maximum amount payable by this plan for covered services received each benefit year.

What is an exclusion period?

A member must be enrolled under the plan for the period of time stated above before this plan pays benefits. The exclusion period is waived for members who are covered under this plan on the plan's original effective date if the member was continuously covered under a predecessor plan of the employer.

Prior authorization

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