PacificSource HEALTH PLANS

Medical Benefit Summary
PSN / Voyager
250+20_20 S3

City of Hillsboro

Provider Network: **PSN** / **Voyager**

Deductible Per Calendar Year	In-network and Out-of-network	
Individual/Family	$250/$750	
Out-of-Pocket Limit Per Calendar Year	**In-network**	**Out-of-network**
Individual/Family	$2,250/$4,750	$4,250/$8,750

Note: Your actual costs for services provided by an out-of-network provider may exceed this policy'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	No deductible, $20	After deductible, 40%
Naturopath office visits	No deductible, $20	After deductible, 40%
Specialist office and home visits	No deductible, $20	After deductible, 40%
Telemedicine visits	No deductible, $10	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%
Outpatient at ambulatory surgery center	After deductible, 10%	After deductible, 40%

Service/Supply	In-network Member Pays	Out-of-network Member Pays
Chiropractic manipulations, acupuncture and massage therapy ($1,500 per benefit year)	No deductible, $20	No deductible, $20
Hospital Services		
Inpatient room and board	After deductible, 20%	After deductible, 40%
Inpatient rehabilitation and habilitation services	After deductible, 20%	After deductible, 40%
Skilled nursing facility care	After deductible, 20%	After deductible, 40%
Outpatient Services		
Outpatient surgery/services	After deductible, 20%	After deductible, 40%
Advanced diagnostic imaging	After deductible, 20%	After deductible, 40%
Diagnostic and therapeutic radiology/lab	No deductible up to $400, then after deductible, 20%	After deductible, 40%
Urgent and Emergency Services		
Urgent care center visits	No deductible, $20	After deductible, 40%
Emergency room visits – medical emergency	After deductible, $100 plus 20%^	After deductible, $100 plus 20%^
Emergency room visits – non-emergency	After deductible, $100 plus 20%^	After 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, 20%	After deductible, 40%
Mental Health and Substance Use Disorder Services		
Office visits	No deductible, $20	After deductible, 40%
Inpatient care	After deductible, 20%	After deductible, 40%
Residential programs	After deductible, 20%	After deductible, 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, 0%	After deductible, 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 medical 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 providers when it comes to meeting your out-of-pocket limit. Only in-network provider expense applies to the in-network provider out-of-pocket limit. Only out-of-network provider expense applies to the out-of-network provider 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 5-25-50 S2 PDL

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.

PacificSource Expanded 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. Preventive drugs are taken to help avoid many illnesses and conditions. You can get a list of covered preventive drugs by contacting our Customer Service team or visit PacificSource.com/drug-list to view the PacificSource Expanded No Cost Drug List.

Each time a covered prescription is dispensed, you are responsible for the amounts below:

Service/ Supply	Tier 1 Member Pays	Tier 2 Member Pays	Tier 3 Member Pays
In-network Retail Pharmacy^			
Up to a 30 day supply:	No deductible, $5	No deductible, $25	No deductible, $50
31 – 60 day supply:	No deductible, $10	No deductible, $50	No deductible, $100
61 – 90 day supply:	No deductible, $15	No deductible, $75	No deductible, $150
In-network Mail Order Pharmacy			
Up to a 30 day supply:	No deductible, $5	No deductible, $25	No deductible, $50
31 – 90 day supply:	No deductible, $10	No deductible, $50	No deductible, $100
Compound Drugs**			
Up to a 30 day supply:		No deductible, $50	
31 – 60 day supply:		No deductible, $100	
61 – 90 day supply:		No deductible, $150	
Out-of-network Pharmacy			
30 day max fill, no more than three fills allowed per year:		Same as retail	

Service/ Supply	Tier 1 Member Pays	Tier 2 Member Pays	Tier 3 Member Pays
Specialty Drugs – In-network Specialty Pharmacy			
Up to a 30 day supply:	Same as retail		
Specialty Drugs – Out-of-network Specialty Pharmacy			
30 day max fill, no more than three fills allowed per year:	No deductible, 90%		

^Remember to show your PacificSource member ID card each time you fill a prescription at a retail pharmacy. If your ID card is not used, your benefits cannot be applied and may result in higher out-of-pocket cost.

**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 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 co-payment and/or co-insurance 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 co-payment and/or co-insurance. The cost difference between the brand name and generic drug does not apply toward the medical plan's 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.