PacificSource HEALTH PLANS

MEDICAL BENEFIT SUMMARY — PREFERRED 300+25 VAR 0711

POLICY INFORMATION

Group Name:	City of Springfield - Preferred Plan
Group Number:	G0020720
Plan Name:	PREFERRED 300+25 VAR 0711
Provider Network:	PSN

EMPLOYEE ELIGIBILITY REQUIREMENTS

Minimum Hour Requirement:	Twenty (20) Hours
Waiting Period for New Employees:	Per Employer Policy

SCHEDULE OF BENEFITS

Maximum Lifetime Benefit No Overall Lifetime Limit

Annual Deductible $300 per person / $900 per family

The deductible is an amount of covered medical expenses the member pays each calendar year before the plan's benefits begin. The deductible applies to all services and supplies except those marked with a bullet (•). Once a member has paid a total amount toward covered expenses during the calendar year equal to the per person amount listed above, the deductible will be satisfied for that person for the rest of that calendar year. Once any covered family members have paid a combined total toward covered expenses during the calendar year equal to the per family amount listed above, the deductible will be satisfied for all covered family members for the rest of that calendar year. Deductible expense is not applied to the out-of-pocket limit.

Out-of-Pocket Limit

Participating Providers	$2,000 per person / $4,000 per family per calendar year
Nonparticipating Providers	$5,000 per person per calendar year

Only participating provider expense applies to the participating provider out-of-pocket limit and only nonparticipating provider expense applies to the nonparticipating out-of-pocket limit. Once the participating provider out-of-pocket limit has been met, this plan will pay 100% of covered charges (after the copayment is deducted) for participating and network not available providers for the rest of that calendar year. Once the nonparticipating provider out-of-pocket limit has been met, this plan will pay 100% of covered charges (after the copayment is deducted) for nonparticipating providers for the rest of that calendar year. Deductibles, copayments, benefits paid in full and nonparticipating provider charges in excess of the PacificSource allowable fee do not accumulate toward the out-of-pocket limit. Copayments and nonparticipating provider charges in excess of the PacificSource allowable fee will continue to be the member's responsibility even after the out-of-pocket limit is met.

SERVICE:	COPAY:	PARTICIPATING PROVIDER/ NETWORK NOT AVAILABLE BENEFIT AFTER COPAY:	NONPARTICIPATING PROVIDER BENEFIT AFTER COPAY:
PREVENTIVE CARE			
• Well Baby Care		100%	80%
• Routine Physicals		100%	80%
• Routine Gynecological Exams		100%	80%
• Immunizations		100%	80%
Routine Colonoscopy		• 100%	60%
PROFESSIONAL SERVICES			
• Office and Home Visits	$25 per visit	100%	80%
• Office Procedures and Supplies		100%	80%
• Urgent Care Center Visits	$25 per visit	100%	80%
Surgery		80%	60%
Physical Therapy		80%	70%
HOSPITAL SERVICES			
Inpatient Room and Board		80%	60%
Inpatient Rehabilitative Care		80%	60%
Skilled Nursing Facility Care		80%	60%
OUTPATIENT SERVICES			
Outpatient Surgery/Services		80%	60%
Advanced Imaging		80%	60%

This is only a brief summary of benefits. Please refer to the additional information provided for a further explanation of benefits including limitations and exclusions.

SERVICE:	COPAY:	PARTICIPATING PROVIDER/ NETWORK NOT AVAILABLE BENEFIT AFTER COPAY:	NONPARTICIPATING PROVIDER BENEFIT AFTER COPAY:
• Diagnostic and Therapeutic Radiology and Lab		80%	60%
•✶ Emergency Room Visits	$100 per visit	80%	60%
MENTAL HEALTH/CHEMICAL DEPENDENCY SERVICES			
• Office Visits	$25 per visit	100%	80%
Inpatient Care		80%	60%
Residential Programs		80%	60%
OTHER COVERED SERVICES			
• Allergy Injections	$5 per visit	100%	80%
Ambulance, Ground		80%	80%
Ambulance, Air		50%	50%
Durable Medical Equipment		80%	50%
Home Health Care		80%	50%
Temporomandibular Joint (TMJ) Services		50%	50%
• Chiropractic / Naturopathic / Acupuncture	$25 per visit	100%	80%

✶ Copay waived if admitted into hospital. In true medical emergencies, nonparticipating providers are paid at the participating provider level.

• Not subject to annual deductible.

Payment to providers is based on the prevailing or contracted PacificSource fee allowance for covered services. Although participating providers accept the fee allowance as payment in full, nonparticipating providers may not. Services of nonparticipating providers could result in out-of-pocket expense in addition to the percentage indicated. Network Not Available payment is allowed when PacificSource has not contracted with providers in the geographical area of the member's residence or work for a specific service or supply. Payment to providers for Network Not Available is based on the usual, customary, and reasonable charge for the geographical area in which the charge is incurred. For more information, refer to the Payment to Providers section in the proposal or member benefit handbook.

Your group insurance plan covers vision exams, eyeglasses, and contact lenses. The following shows the vision benefits available.

BENEFIT PERIOD

Eye Exam: Once every 12 months age 17 and younger, every 24 months age 18 and older
Lenses: One pair every 12 months age 17 and younger, every 24 months age 18 and older
Frames: One every 12 months age 17 and younger, every 24 months age 18 and older
Contact Lenses: Once every 12 months age 17 and younger, every 24 months age 18 and older

SERVICE/SUPPLY	Participating Provider Benefit	Nonparticipating Provider Benefit
Eye Exam	100%	$40
Hardware		
* **Lenses (maximum per pair)**		
➢ Single Vision	100%	$56
➢ Bifocal	100%	$84
➢ Trifocal	100%	$116
➢ Lenticular	100%	$236
Progressive	$116	$116
* **Frames**	$75	$75
* **Contacts (in place of glasses)**	$131	$131

* Participating Providers discount these services.

➢ *Participating Providers accept these benefit amounts as payment in full.*

The amounts listed above are the maximum benefits available for all vision exams, lenses, and frames furnished during any benefit period. If charges for a service or supply are less than the amount allowed, the benefit will be equal to the actual charge. If only one lens is supplied, the allowance for the lens is 50 percent of the lens allowance shown above.

Limitations and Exclusions

The out-of-pocket expense for vision services (copayments and service charges) does not apply to the medical deductible or out-of-pocket limit of the policy. Also, the member continues to be responsible for the vision copayments and service charges regardless of whether the policy's out-of-pocket limit is satisfied.

Covered expenses do not include, and no benefits are payable for:

- Special procedures such as orthoptics or vision training
- Special supplies such as sunglasses (plain or prescription) and subnormal vision aids
- Tint
- Plano contact lenses
- Anti-reflective coatings and scratch resistant coatings
- Separate charges for contact lens fitting
- Replacement of lost, stolen, or broken lenses or frames
- Duplication of spare eyeglasses or any lenses or frames
- Nonprescription lenses
- Visual analysis that does not include refraction
- Services or supplies not listed as covered expenses
- Charges for services or supplies covered in whole or in part under any other medical or vision benefits provided by the employer
- Eye exams required as a condition of employment, or required by a labor agreement or government body
- Expenses covered under any workers' compensation law.
- Services or supplies received before this plan's coverage begins or after it ends.
- Medical or surgical treatment of the eye

- Network Not Available - 100% of UCR

Important information about your vision benefits

Your PacificSource health insurance package includes coverage for vision services, including prescription eyeglasses and contact lenses. To make the most of those benefits, it's important to keep in mind the following:

- **Participating 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**
  Please remember to show your current PacificSource ID card whenever you use your plan's benefits. Our provider contracts require participating providers to bill us directly whenever you receive covered services and supplies. Providers normally call PacificSource to verify your vision benefits, then bill us directly. Participating 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 allowances. If you are asked to pay the entire amount in advance, tell the provider you understand they have a contract with PacificSource and should bill PacificSource directly.
- **Sales and Special Promotions**
  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 participating providers already discount their services through their contract with PacificSource, your plan's participating provider benefits cannot be combined with any other discounts or coupons. You can use your plan's participating provider benefits, or you can use your plan's nonparticipating provider benefits to take advantage of a sale or coupon offer. If you do take advantage of a special offer, the participating 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 nonparticipating provider benefits.

We hope this information helps clarify your vision benefits. If you or your provider have any questions about your benefits, please call PacificSource Customer Service at (541) 686-1242 from Eugene-Springfield or (888) 977-9299 from other areas.

Your plan's alternative care benefit allows you to receive treatment from the licensed alternative care providers listed below for medically necessary diagnosis and treatment of illness or injury. Refer to the Medical Benefit Summary for your copayment and/or coinsurance information.

PacificSource contracts with a network of alternative care providers, so you can reduce your out-of-pocket expense by using one of the Participating Providers. For a listing of participating alternative care providers in your area, please refer to your plan's Participating Provider directory, visit our Web site, www.pacificsource.com, or call our Customer Service Department.

Covered Services

- Services of a licensed naturopath for medically necessary diagnosis and treatment of illness or injury.
- Acupuncture services of a licensed acupuncturist (under ORS677.757 to ORS677.770) or physician when necessary for diagnosis and treatment of illness or injury.
- Services of a licensed chiropractor for medically necessary diagnosis and treatment of illness or injury, including chiropractic manipulations and chiropractic massage therapy.

The combined benefit for all treatments, services, and supplies provided or ordered by an alternative care provider is limited to $1,000 per person in any calendar year. That amount includes, but is not limited to, covered charges for any laboratory services, x-rays, radiology, and durable medical equipment provided by or ordered by an alternative care provider.

Excluded Services

- Any service or supply excluded or not otherwise covered by the medical plan.
- Drugs, homeopathic medicines, or homeopathic supplies furnished by an alternative care provider.
- Services of an alternative care provider for pregnancy or childbirth.

Your PacificSource health plan includes coverage for prescription drugs and certain other pharmaceuticals, subject to the information below. Your prescription drug plan qualifies as creditable coverage for Medicare Part D.

COPAYMENTS (other than for Specialty Drugs)
Each time a covered pharmaceutical is dispensed, you are responsible for a copayment as follows:

From a participating retail pharmacy using the PacificSource Pharmacy Program (see below):	**Tier 1: Generic**	**Tier 2: Formulary**	**Tier 3: Nonformulary**
Up to 30-day supply:	$15	$30	$50
31 to 60-day supply:	$30	$60	$100
61 to 90 day supply:	$45	$90	$150
From a participating mail order service (see below):			
Up to a 30-day supply:	$15	$30	$50
31 to 90 day supply:	$37.50	$75	$125
From a participating retail pharmacy without using the PacificSource Pharmacy Program, or from a nonparticipating pharmacy (see below):	50% or the retail pharmacy copayment above, whichever is greater		

CAREMARK® SPECIALTY PHARMACY PROGRAM
CVS Caremark® Specialty Pharmacy Services is our exclusive provider for high-cost injectable medications and biotech drugs. A pharmacist-led CareTeam provides individual follow-up care and support to our members with prescriptions for specialty medications. The CareTeam provides comprehensive disease education and counseling, assesses patient health status, and offers a supportive environment for patient inquiries. We ensure that our members receive strong clinical support, as well as the best drug pricing for these specific medications and biotech drugs. More information regarding health conditions and a complete list of medications covered under this program are available on the PacificSource Web site.

COPAYMENTS FOR SPECIALTY DRUGS
Participating provider benefits for specialty drugs are available when you use the special pharmacy program of participating specialty pharmacy. The specialty pharmacy is not available through the PacificSource participating retail pharmacy network or participating mail order service. Participating provider benefits for specialty drugs are available at a retail pharmacy only when preauthorized by PacificSource. An up-to-date list of drugs requiring preauthorization and/or are subject to pharmaceutical service restrictions is available on the PacificSource Web site. Each time a specialty drug is dispensed, you are responsible for a copayment as follows:

From a participating specialty pharmacy:	
Up to 30-day supply:	$100 or 20%, whichever is less
From a participating retail pharmacy, from a participating mail order service, or from a nonparticipating pharmacy or pharmaceutical service provider:	Not covered (except 5-day emergency supply only)

WHAT HAPPENS WHEN A BRAND NAME DRUG IS SELECTED
Unless the doctor requires the use of a brand name drug, the prescription will automatically be filled with a generic drug when available and permissible by Oregon law. If you receive a brand name drug when a generic is available, you must pay the brand name drug's copayment plus the difference in cost between the brand name drug and its generic equivalent.

USING THE PACIFICSOURCE PHARMACY PROGRAM

To use the PacificSource pharmacy program, you must show the pharmacy plan number on the PacificSource ID card at the participating pharmacy to receive the plan's highest benefit level.

When obtaining prescription drugs at a participating retail pharmacy, the PacificSource pharmacy program can only be accessed through the pharmacy plan number printed on the PacificSource ID card. That plan number allows the pharmacy to collect the appropriate copayment from you and bill PacificSource electronically for the balance. When the pharmacy plan number is not used at the time of purchase, PacificSource will reimburse you for prescription drug expense after subtracting the out of plan copayment shown above.

MAIL ORDER SERVICE

This plan includes a participating mail order service for prescription drugs. Most, but not all, covered prescription drugs are available through this service. Questions about availability of specific drugs may be directed to the PacificSource Customer Service Department or to the plan's participating mail order service vendor. Forms and instructions for using the mail order service are available from PacificSource and on the PacificSource Web site.

OTHER COVERED PHARMACEUTICALS

Supplies covered under the pharmacy plan are in place of, not in addition to, those same covered supplies under the medical plan. Copayments for items in this section are applied on the same basis as for other prescription drugs, unless otherwise noted.

Diabetic Supplies

- Insulin and diabetic syringes are available.
- Lancets and test strips are available.
- Glucagon recovery kits are available for the plan's formulary copayment. The member may purchase up to two kits at one time, but no more than four kits in any calendar year (unless preauthorized by PacificSource).
- Glucostix and glucose monitoring devices are not covered under this pharmacy benefit, but are covered under the medical plan's durable medical equipment benefit.

Bee Sting Kits

Anaphylactic recovery kits for people with severe allergic reactions to bee stings are available for the plan's nonformulary name copayment. You may purchase up to two kits at one time, but no more than four kits in any calendar year (unless otherwise preauthorized by PacificSource).

Contraceptives

- Oral contraceptives
- Implantable contraceptives, contraceptive injections, contraceptive patches, and contraceptive rings are available.
- Diaphragm or cervical caps are available.

Tobacco Use Cessation

Program specific tobacco cessation medications are covered with active participation in a covered tobacco use cessation program (see Preventive Care in the policy's Covered Expenses section).

Orally Administered Anticancer Medications

Orally administered anticancer medications used to kill or slow the growth of cancerous cells are available. Copayments for orally administered anticancer medication are applied on the same basis as for other drugs. Orally administered anticancer medications covered under the pharmacy plan are in place of, not in addition to, those same covered drugs under the medical plan.

LIMITATIONS AND EXCLUSIONS

- This plan only covers drugs prescribed by a licensed physician (or other licensed practitioner eligible for reimbursement under the plan) prescribing within the scope of his or her professional license, except for:
  - Over-the-counter drugs or other drugs that federal law does not prohibit dispensing without a prescription (even if a prescription is required under state law).
  - Drugs for any condition excluded under the health plan. That includes drugs intended to promote fertility, treatments for obesity or weight loss, tobacco cessation drugs (except as specifically provided for under Other Covered Pharmaceuticals), experimental drugs, drugs prescribed or used for cosmetic purposes, and drugs available without a prescription (even if a prescription is provided).
  - Some specialty drugs that are not self-administered are not covered by this pharmacy benefit, but are covered

under the medical plan's office supply benefit.

  - Immunizations (although not covered by this pharmacy benefit, immunizations may be covered under the medical plan's preventive care benefit.)
  - Drugs and devices to treat erectile dysfunction.
  - Drugs used as a preventive measure against hazards of travel.
- Certain drugs require preauthorization by PacificSource in order to be covered. An up-to-date list of drugs requiring preauthorization is available on the PacificSource Web site.
- Certain drugs are subject to step therapy protocols. An up-to-date list of drugs subject to step therapy protocols is available on the PacificSource Web site.
- PacificSource may limit the dispensing quantity through the consideration of medical necessity, generally accepted standards of medical practice, and review of medical literature and governmental approval status.
- Quantities for any drug filled or refilled are limited to no more than a 90-day supply when purchased at retail pharmacy or a 90-day supply when purchased through mail order pharmacy service or a 30-day supply when purchased through a specialty pharmacy.
- For drugs purchased at nonparticipating pharmacies or at participating pharmacies without using the PacificSource pharmacy program, reimbursement is limited to an allowable fee. That fee is the wholesale acquisition cost of the medication plus 20%.
- The out-of-pocket expense for prescription drugs (copayments and service charges) does not apply to the medical deductible or out-of-pocket limit of the policy. Also, the member continues to be responsible for the prescription drug copayments and service charges regardless of whether the policy's out-of-pocket limit is satisfied.
- Prescription drug benefits are subject to the plan's coordination of benefits provision. (See Coordination of Benefits in the policy's General Limitations section.)

GENERAL INFORMATION ABOUT PRESCRIPTION DRUGS

Formulary Drugs

A drug formulary is a list of preferred medications used to treat various medical conditions. The formulary is used to help control rising healthcare costs while ensuring that you receive medications of the highest quality. It is a guide for your doctor and pharmacist in selecting drug products that are safe, effective, and cost efficient. The formulary is made up both generic and brand name products. The formualry is developed by Caremark® in cooperation with PacificSource. Nonformulary drugs are covered brand name medications not on the formulary.

Generic Drugs

Generic drugs are equivalent to name brand medications. Name brand medications (such as Valium) lose their patent protection after a number of years. At that time any drug company can produce the drug, and the manufacturer must pass the same strict FDA standards of quality and product safety as the original manufacturer. Generic drugs are less expensive than brand name drugs because there is more competition and there is no need to repeat costly research and development. Your pharmacist and doctor are encouraged to use generic drugs whenever they are available.

Step Therapy

Step therapy means a program that requires the member to try lower-cost alternative medications (Step 1 drugs) before using more expensive medications (Step 2 drugs). The program will not cover a brand name, or second-line medication, until less expensive, first-line/generic medications in the same therapeutic class have been tried first.