

Marion County Non-MCLEA

Benefit Year: Calendar Year

Provider Network: Navigator

| Deductible Per Benefit Year | In-network and Out-of-network | |
|---|-------------------------------|-------------------|
| Individual/Family | \$300/\$900 | |
| Out-of-Pocket Limit Per Benefit Year | In-network | Out-of-network |
| Individual/Family | \$5,000/\$10,000 | \$10,000/\$20,000 |
| <p>Note: 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 situations 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.</p> | | |

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, 50% |
| Preventive physicals | No deductible, 0% | After deductible, 50% |
| Well woman visits | No deductible, 0% | After deductible, 50% |
| Preventive mammograms | No deductible, 0% | After deductible, 50% |
| Immunizations | No deductible, 0% | After deductible, 50% |
| Preventive colonoscopy | No deductible, 0% | After deductible, 50% |
| Prostate cancer screening | No deductible, 0% | After deductible, 50% |
| Professional Services | | |
| Office and home visits | First three visits no deductible, \$5. Subsequent visits, no deductible, \$15* | After deductible, 50% |
| Naturopath office visits | No deductible, \$15 | After deductible, 50% |

| Service/Supply | In-network Member Pays | Out-of-network Member Pays |
|--|--|--|
| Specialist office and home visits | No deductible, \$15 | After deductible, 50% |
| Telehealth visits | First three visits no deductible, \$5. Subsequent visits, no deductible, \$15* | After deductible, 50% |
| Office procedures and supplies | After deductible, 30% | After deductible, 50% |
| Surgery | After deductible, 30% | After deductible, 50% |
| Outpatient rehabilitation and habilitation services | After deductible, 30% | After deductible, 50% |
| Acupuncture (12 visits per benefit year) | No deductible, 30% | No deductible, 30% |
| Chiropractic manipulation/Spinal manipulation (20 visits per benefit year) | No deductible, 30% | No deductible, 30% |
| Hospital Services | | |
| Inpatient room and board | After deductible, \$100/admit plus 30% | After deductible, \$100/admit plus 50% |
| Inpatient rehabilitation and habilitation services | After deductible, \$100/admit plus 30% | After deductible, \$100/admit plus 50% |
| Skilled nursing facility care | After deductible, \$100/admit plus 30% | After deductible, \$100/admit plus 50% |
| Outpatient Services | | |
| Outpatient medical surgery/services | After deductible, 30% | After deductible, 50% |
| Outpatient dental surgery/services | After deductible, \$100 plus 30% | After deductible, \$100 plus 50% |
| Outpatient at ambulatory surgery center | After deductible, 20% | After deductible, 50% |
| Diagnostic imaging – advanced | After deductible, \$100/test plus 30% | After deductible, \$100/test plus 50% |
| Diagnostic and therapeutic radiology/laboratory and dialysis – non-advanced | No deductible, 30% | After deductible, 50% |
| Urgent and Emergency Services | | |
| Urgent care center visits | No deductible, \$15 | After deductible, 50% |

| Service/Supply | In-network Member Pays | Out-of-network Member Pays |
|--|--|--|
| Emergency room visits – medical emergency | No deductible, \$200 plus 30%^ | No deductible, \$200 plus 30%^ |
| Emergency room visits – non-emergency | No deductible, \$200 plus 30%^ | No deductible, \$200 plus 30%^ |
| Ambulance, ground | After deductible, 30% | After deductible, 30% |
| Ambulance, air | After deductible, 30% | After deductible, 30% |
| Maternity Services** | | |
| Physician/Provider services (global charge) | After deductible, 30% | After deductible, 50% |
| Hospital/Facility services | After deductible, \$100/admit plus 30% | After deductible, \$100/admit plus 50% |
| Mental Health and Substance Use Disorder Services | | |
| Office visits | First three visits no deductible, \$5. Subsequent visits, no deductible, \$15* | No deductible, 50% |
| Inpatient care | After deductible, \$100/admit plus 30% | After deductible, \$100/admit plus 50% |
| Residential programs | After deductible, \$100/admit plus 30% | After deductible, \$100/admit plus 50% |
| Other Covered Services | | |
| Allergy injections | After deductible, 30% | After deductible, 50% |
| Durable medical equipment | After deductible, 30% | After deductible, 50% |
| Home health services | After deductible, 30% | After deductible, 50% |
| Transplants | After deductible, \$100/admit plus 30% | After deductible, \$100/admit plus 50% |

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

^ Copay applies to ER physician and facility charges only. Copay waived if admitted into hospital.

*First three 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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Benefit Year: Calendar Year

Formulary: Preferred Drug List (PDL)

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.

PacificSource Expanded (Preventive) No-cost Drug List

Your prescription benefit includes certain outpatient drugs as a preventive benefit at no deductible, \$0 copay. 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 and select Find a Drug.

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 when filled at an in-network pharmacy. 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 | Incentive Drugs: | Tier 1 Member Pays | Tier 2 Member Pays | Tier 3 Member Pays |
|---------------------------------------|-------------------------|-------------------------------|-------------------------------|-------------------------------|
| In-network Retail Pharmacy | | | | |
| Up to a 30 day supply: | No deductible, 0% | No deductible, \$10* | No deductible, \$30* | No deductible, 50%* |
| 31 - 60 day supply: | No deductible, 0% | No deductible, \$20 | No deductible, \$60 | No deductible, 50% |
| 61 - 90 day supply: | No deductible, 0% | No deductible, \$30 | No deductible, \$90 | No deductible, 50% |
| In-network Mail Order Pharmacy | | | | |
| Up to a 30 day supply: | No deductible, 0% | No deductible, \$10* | No deductible, \$30* | No deductible, 50%* |

| Service/ Supply | Incentive Drugs: | Tier 1 Member Pays | Tier 2 Member Pays | Tier 3 Member Pays |
|--|-------------------------|-------------------------------|-------------------------------|-------------------------------|
| 31 - 60 day supply: | No deductible, 0% | No deductible, \$20 | No deductible, \$60 | No deductible, 50% |
| 61 - 90 day supply: | No deductible, 0% | No deductible, \$30 | No deductible, \$90 | No deductible, 50% |
| Compound Drugs** | | | | |
| Up to a 90 day supply: | | | | No deductible, 50% |
| Out-of-network Pharmacy | | | | |
| 30 day maximum fill, no more than three fills allowed per year: | | | | No deductible, 50% |
| Tier 1, Tier 2, and Tier 3 Member Pays | | | | |
| Specialty Drugs - In-network Specialty Pharmacy | | | | |
| Up to a 30 day supply: | | | | No deductible, \$50 |
| Specialty Drugs - Out-of-network Specialty Pharmacy | | | | |
| 30 day maximum fill, no more than three fills allowed per year: | | | | No deductible, \$50 |

*Prescription insulin is not subject to a deductible and is limited to \$35 copay per 30 day supply when filled at an in-network pharmacy.

**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.

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 copayment and/or coinsurance plus the difference in cost between the brand name and generic drug. 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 exception review 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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Benefit Year: Calendar 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, \$10 | No deductible, \$10 then 0% up to \$45 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, \$10 | No deductible, \$10 then 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% |
| Lens treatments | No deductible, 0% up to \$50 then 100% | Included in lenses allowance |
| Frames | No deductible, 0% up to \$200 then 100% | No deductible, 0% up to \$70 then 100% |
| Contact Lenses (in lieu of glasses) | | |
| Contact lenses | No deductible, 0% up to \$200 then 100% | No deductible, 0% up to \$105 then 100% |

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.
- Lenses: One pair every benefit year.
- Frames: Once every benefit year.
- Contact lenses: Once every benefit year.
- Elective contact lenses are in lieu of frames and lenses.
- Anti-reflective coatings, scratch resistant coatings, lens tints and polycarbonate lenses 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.
- Non-prescription lenses.
- Plano contact lenses.
- Replacement of lost, stolen, or broken lenses or frames.
- 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.
- Special supplies, such as sunglasses and subnormal vision aids.
- 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.