Draft Summary based on College Proposal

CLASSIFIED EMPLOYEE PLAN SUMMARY

Medical Benefit PacificSource Preferred PSN Plan	$500 Deductible (PSN OR Smartchoice) In-Network Provider	 Out-of-Network	$750 Deductible (PSN or Smartchoice) In-Network Provider	 Out-of-Network	$1000 Deductible (PSN or Smartchoice) In-Network Provider	 Out-of-Network
Individual deductible per calendar year	$500	$1,000	$750	$1,500	$1,000	$2,000
Family deductible per calendar year	$1,250	$2,500	$1,875	$3,750	$2,500	$5,000
Individual out-of-pocket maximum per calendar year	$2,000*	$3,250*	$3,250*	$5,250*	$4,000*	$6,500*
Family out-of-pocket maximum per calendar year	$4,250*	$7,000*	$6,875*	$11,250*	$8,500*	$14,000*
After out-of-pocket max is met each calendar year, the plan pays	100%	100%	100%	100%	100%	100%
Preventative Care Services and Office Visits	**Deductible Waived The Plan Pays**	**After Deductible The Plan Pays**	**Deductible Waived The Plan Pays**	**After Deductible The Plan Pays**	**Deductible Waived The Plan Pays**	**After Deductible The Plan Pays**
Office and Home visit co-payment (includes Naturopath)	100% after $25 co-pay	60%	100% after $25 co-pay	60%	100% after $25 co-pay	60%
Immunizations all ages (subject to preventative care schedule)	100%	Not Covered	100%	Not Covered	100%	Not Covered
Well-baby Care (subject to preventative care schedule)	100%	Not Covered	100%	Not Covered	100%	Not Covered
Routine Physical Exam (subject to preventative care schedule)	100%	Not Covered	100%	Not Covered	100%	Not Covered
Annual Women's Exam including pap test and mammogram	100%	60%	100%	60%	100%	60%
Children's Vision and Hearing Exams	100%	Not Covered	100%	Not Covered	100%	Not Covered
Preventative Care Colonoscopy	100%	60%	100%	60%	100%	60%
Urgent Care Centers	100% after $25 co-pay	60%	100% after $25 co-pay	60%	100% after $25 co-pay	60%
Outpatient Mental Health/Chemical Dependency**	100% after $25 co-pay	60%	100% after $25 co-pay	60%	100% after $25 co-pay	60%
Female Sterilization	100%	60%	100%	60%	100%	60%
Male Sterilization	100%	60%	100%	60%	100%	60%
Facility Benefits	**After Deductible - The Plan Pays**		**After Deductible - The Plan Pays**		**After Deductible - The Plan Pays**	
Hospital Inpatient Room and Board	80%	60%	80%	60%	80%	60%
Inpatient Rehabilitative Care	80%	60%	80%	60%	80%	60%
Nursery Care	80%	60%	80%	60%	80%	60%
Surgery	80%	60%	80%	60%	80%	60%
Inpatient and Residential Mental Health/Chemical Dependency Programs**	80%	60%	80%	60%	80%	60%
Skilled Nursing Facility (up to 60 days per calendar year)	80%	60%	80%	60%	80%	60%
Emergency Room Co-payment (waived if admitted)	$100	$100	$100	$100	$100	$100
Emergency Room Care (co-pay waived if admitted)	80% after $100 co-pay	60% after $100 co-pay	80% after $100 co-pay	60% after $100 co-pay	80% after $100 co-pay	60% after $100 co-pay
Other Services	**After Deductible - The Plan Pays**		**After Deductible - The Plan Pays**		**After Deductible - The Plan Pays**	
Diagnostic/Therapeutic Radiology and Lab	80%	60%	80%	60%	80%	60%
CT/PET Scans, CATH Labs and MRIs	80%	60%	80%	60%	80%	60%
Therapeutic Injections, including allergy shots	80%	60%	80%	60%	80%	60%
Outpatient Surgery (requires pre-authorization)	80%	60%	80%	60%	80%	60%
Hearing Aid (maximum of $800 every 3 years)	80%	60%	80%	60%	80%	60%
Physical Therapy	80%	60%	80%	60%	80%	60%
Naturopath (other than office visit)	80%	60%	80%	60%	80%	60%
Hospice (plan limits may apply)	80%	60%	80%	60%	80%	60%
Home Health Care (plan limits may apply)	80%	50%	80%	50%	80%	50%
Durable Medical Equipment and Supplies	80%	60%	80%	60%	80%	60%
Anesthesiologist	80%	60%	80%	60%	80%	60%
Ambulance (including ground and air)	80%	80%	80%	80%	80%	80%
Outpatient Rehabilitation (plan limits may apply)	80%	60%	80%	60%	80%	60%
TMJ treatment ($3000 lifetime maximum)	80%	60%	80%	60%	80%	60%
Family Planning	**After Deductible - The Plan Pays**		**After Deductible - The Plan Pays**		**After Deductible - The Plan Pays**	
Infertility (limited benefit)	50%	50%	50%	50%	50%	50%
Alternative Care	**After Deductible - The Plan Pays**		**After Deductible - The Plan Pays**		**After Deductible - The Plan Pays**	
Chiropractor (24 visits per year)	80%	80%	80%	80%	80%	80%
Massage/Accupunture (24 visits per year)	80%	80%	80%	80%	80%	80%

* Out-of-Pocket Maximum includes all medical, vision and Rx services (deductible, co-payments and co-insurance amounts combined)

** Subject to state-mandated limitations.

Prescription Medications PacificSource Preferred Drug List (PDL) Plan	Tier 1: Generic	Tier 2: Preferred	Tier 3: Nonpreferred
Medications purchased from a participating retail pharmacy (Up to a 34-day supply)	$15 co-pay	$30 co-pay	$50 co-pay
Medications purchased from a participating mail order service (Up to a 90-day supply)	$15 co-pay	$60 co-pay	$100 co-pay

For more information on the tiered pharmacy benefit, please see the bottom of page 2 of this summary.

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Vision Benefit - subject to change pending contract revisions	In-Network The Plan Pays	Out-of-Network The Plan Pays
Examination (one per calendar year)	100%	100% up to $64.50
Lenses (one pair every calendar year)		
Single vision lenses	100% up to $105	
Bifocal lenses	100% up to $130	
Trifocal lenses	100% up to $150	
Lenticular lenses	100% up to $236	
Progressive lenses	100% up to $116	
Frames (one pair every two calendar years)	100% up to $125	
Contact Lens (one pair per calendar year in place of glasses)	100% up to $230	

Dental Benefits	Moda Health (formerly ODS)	Willamette Dental
Office Visit	No charge	$10
Annual Benefit Maximum	$2,000	None
Deductible	$25/member; $75/family	None
Preventive and Diagnostic Services - Class I		
Oral exams, X-rays, cleaning (prophylaxis), fluoride treatments, and space maintainers	100%	100%*
Restorative Services - Class II		
Routine fillings	80% after deductible[1]	100%*[2]
Simple Tooth Extractions	80% after deductible	100%*
Surgical tooth extractions, including diagnosis and evaluation	80% after deductible	100%*
Diagnosis, evaluation, and treatment of gum disease including scaling and root planing	80% after deductible	100%*
Root canal and related therapy including diagnosis and evaluation	80% after deductible	100%*
Major Restorative Services - Class III		
Gold or porcelain crowns	60% after deductible[1]	100%*
Full and partial dentures	60% after deductible	100%*
Bridge retainers and pontics	60% after deductible	100%*
Orthodontics	Not covered	$1,500 co-pay + $10 per visit**

Additional Dental Benefits Information

Under Moda Health, services are available through any dentist, whereas Willamette Dental members must see Willamette Dental providers.

*For the Willamette Dental plan, services rendered plus the office visit fee co-pay per visit.

** Pre-Orthodontic Service fee of $150 is credited towards the orthodontic benefit if patient accepts treatment plan.

[1] Posterior fillings and crowns paid to standard materials fees.

[2] Fillings are covered at 100% for all amalgam tooth surfaces, composite anteriors and 1 surface composite posteriors. Patients can request composite fillings, which are considered a buy-up and additional fees apply. Please contact Willamette directly for actual fees.

Additional Pharmacy Benefit Information

WHAT HAPPENS WHEN A BRAND NAME DRUG IS SELECTED? Unless your doctor requires the use of a brand name drug, your pharmacist can fill your prescription 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 co-pay plus the difference in cost between the brand name drug and its generic equivalent. Differential between brand name and generic drugs, and drugs obtained at a nonparticipating pharmacy do not apply toward the Prescription Drug Out-of-Pocket Limit.

Preferred Drugs - A drug formulary is a list of preferred medications used to treat various medical conditions. The formulary for this plan is known as the Preferred Drug List (PDL). The PDL 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 PDL is made up of name brand products. The current PDL includes approximately 650 commonly prescribed brand name medications. A complete list of medications covered under the PDL is available on the For Members area of the PacificSource website, www.pacificsource.com.
Nonpreferred Drugs are covered brand name medications not on the PDL.

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.

MAIL ORDER SERVICE
If you take a medication on a regular basis, mail order service is a convenient way to order prescriptions and have them delivered directly to your home. There is no shipping or handling charge for standard delivery. The two participating mail order service providers are:

WellPartner	CVS Caremark
(877) 568-6460	(866) 329-3051

This is a brief summary of benefits. Please refer to your specific Member Handbook for complete details. Plan benefits are governed by the terms of the group policy, which alone determines benefit payments.