SUMMARY OF BENEFITS –
Corvallis School District Certified

PREFERRED 90+100 VAR

MAXIMUM LIFETIME BENEFIT $2,000,000
ANNUAL DEDUCTIBLE
Participating Providers..$100 per person / $300 per family
Nonparticipating Providers...$200 per person / $600 per family
The deductible is an amount of covered medical and dental 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 an asterisk (*).
OUT-OF-POCKET LIMIT
Participating Providers...$600 per person per calendar year
Nonparticipating Providers...$1,700 per person per calendar year
The medical out-of-pocket limit for participating providers accumulates separately from the medical out-of-pocket limit for nonparticipating providers. Once the participating provider out-of-pocket limit has been met, this plan will pay 100% of covered charges 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 for all providers for the rest of that calendar year. Benefits paid in full, copayments, and nonparticipating provider charges in excess of the PacificSource fee allowance do not accumulate toward the out-of-pocket limit.
ADDITIONAL ACCIDENT $500
The first $500 of covered expense within 90 days of accident is paid at 100% and is not subject to the deductible. The balance is covered as shown below.

	SERVICE:	***PARTICIPATING PROVIDER/ NETWORK NOT AVAILABLE BENEFIT:***	***NONPARTICIPATING PROVIDER BENEFIT:***
	PREVENTIVE CARE		
*	Well Baby Care	100%	100%
*	Routine Physicals	100%	100%
*	Routine Gynecological Exams	100%	100%
*	Immunizations	100%	100%
	PROFESSIONAL SERVICES		
	Office and Home Visits	90%	70%
	Urgent Care Center Visits	90%	70%
	Surgery	90%	70%
	HOSPITAL SERVICES		
	Inpatient Room and Board	90%	70%
	Inpatient Rehabilitative Care	90%	70%
	Skilled Nursing Facility Care	90%	70%
	OUTPATIENT SERVICES		
	Outpatient Surgery	90%	70%
	Diagnostic and Therapeutic Radiology and Lab	90%	70%
	CT/PET Scans, CATH Labs and MRIs	90%	70%
•	Emergency Room Visits	90% after $100 copay	70% after $100 copay
	MENTAL HEALTH/CHEMICAL DEPENDENCY SERVICES		
	Office Visits	90%	70%
	Inpatient Care	90%	70%
	Residential Programs	90%	70%
	OTHER COVERED SERVICES		
	Physical Therapy	80%	70%
	Allergy Injections	90%	70%
	Ambulance	80%	80%
	Durable Medical Equipment	90%	70%
	Home Health Care	80%	70%
	Alternative Care/Chiropractic	80%	60%

• ***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.

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.