

**SUMMARY OF  
BENEFITS –  
Douglas County**



**PRIME HIGH  
15/100D VAR  
Group C063**

**MAXIMUM LIFETIME BENEFIT** .....\$2,000,000

**OUT-OF-POCKET LIMIT** .....\$1,000 per person per calendar year

Once the out-of-pocket limit is reached, payment to participating providers increases to 100% for the remainder of the year. Nonparticipating providers continue to be paid at the percentage stated below. Benefits paid in full, prescription drugs, transplants performed at nonparticipating transplant facilities, nonparticipating providers, and charges in excess of those allowed for services of nonparticipating providers do not accumulate toward the out-of-pocket limit.

**PRIMARY CARE PRACTITIONER** .....All enrolled members must select a primary care practitioner (PCP) from the PacificSource Prime provider directory to be responsible for their continuing medical care. The PCP will coordinate use of healthcare resources to best meet the member’s healthcare needs.

**PROVIDER PANEL/NETWORK**.....Prime PSN (refer to directly at [www.pacificsource.com](http://www.pacificsource.com))

<b>SERVICE:</b>	<b>PCP OR REFERRED BENEFIT:</b>	<b>OUT-OF-PANEL/ NONREFERRED BENEFIT:</b>
<b>PREVENTIVE CARE</b>		
Well Baby Care	100% after \$15 copay	50% after \$15 copay
Routine Physicals	100% after \$15 copay	50% after \$15 copay
Routine Gynecological Exams	100% after \$15 copay	50% after \$15 copay
Immunizations	100%	50%
<b>PROFESSIONAL SERVICES</b>		
Office and Home Visits	100% after \$15 copay	50% after \$15 copay
Urgent Care Center Visits	100% after \$15 copay	50% after \$15 copay
Surgery	100%	50%
<b>HOSPITAL SERVICES</b>		
Inpatient Room and Board	100% after \$100 per day	50% after \$100 per day
Inpatient Rehabilitative Care	100% after \$100 per day	50% after \$100 per day
Skilled Nursing Facility Care	100% after \$100 per day	50% after \$100 per day
<b>OUTPATIENT SERVICES</b>		
Outpatient Surgery	100% after \$100 per admit	50% after \$100 per admit
Diagnostic and Therapeutic Radiology and Lab	100%	50%
CT/PET Scans, CATH Labs and MRIs	100%	50%
• Emergency Room Visits (copay waived if admitted)	100% after \$50 copay	50% after \$50 copay
<b>MENTAL HEALTH/CHEMICAL DEPENDENCY SERVICES</b>		
Office Visits	100% after \$15 copay	50% after \$15 copay
Inpatient Care	100% after \$100 per day	50% after \$100 per day
Residential Programs	100% after \$100 per day	50% after \$100 per day
<b>OTHER COVERED SERVICES</b>		
Physical, Occupational, and Speech Therapy	100% after \$15 copay	50% after \$15 copay
Allergy Injections	100% after \$5 copay	50% after \$5 copay
Ambulance	80%	80%
Durable Medical Equipment	80%	50%
Home Health Care	80%	50%
Hearing Exam/Aid	50%	50%
Temporomandibular joint syndrome (TMJ)	50%	50%
Infertility (medically necessary)	50%	50%

• ***In true medical emergencies, nonparticipating providers are paid at the participating provider level.***

*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. To receive the maximum benefits under this plan, members should first seek treatment from their PCP. 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.***

# SUMMARY OF BENEFITS

Douglas County



# HIGH PRIME LIMITATIONS

Group C063

**GENERAL BENEFIT LIMITATIONS** (see medical handbook for more complete list and details)

**Ambulance** is covered to the nearest facility able to treat the condition up to \$5,000 per calendar year.

**Biofeedback** to treat migraine headaches or urinary incontinence is limited to a lifetime maximum of 10 sessions.

**Cardiac rehabilitation** for Phase I covered under inpatient hospital, Phase II covered as outpatient hospital benefits up to a lifetime maximum benefit of 36 sessions if preauthorized by PacificSource, and Phase III is not covered.

**Contraceptive devices** (IUD, Norplant, diaphragm, cervical cap) and insertion/removal are covered. Devices that can be obtained without a prescription such as condoms, sponges, and spermicides are not covered.

**Diabetic self-management education** covered when diagnosed. Up to three hours of education per year if significant change.

**Durable medical equipment** (DME) is limited to rental cost or purchase price, whichever less. DME over \$500 requires preauthorization. Lenses to correct vision defect resulting from severe medical problem or eye surgery other than refraction procedures has a \$200 maximum. Breast pump rental or purchase limited to \$200 lifetime maximum.

**Hearing aid**, hearing exam, evaluation, and follow up exam are covered up to a combined total of \$500 every 36 months.

**Home healthcare** is covered up to 140 visit maximum per calendar year when preauthorized.

**Hospice care** is covered up to a \$20,000 lifetime maximum when included in an approved hospice treatment plan.

**Infertility** office visits and diagnostic procedures are covered when medically necessary, and includes medication to preserve fertility during treatment with catatonic chemotherapy. In vitro fertilization and procedures are not covered.

**Mental health and chemical dependency** treatment and services are subject to the same standards for medical necessity and experimental and investigational criteria as other medical conditions. Outpatient visits in excess of the first eight visits are subject to review of the continuation of treatment, or post-treatment review. Long-term residential mental health programs exceeding 45 days per calendar year will not be authorized.

**Organ Transplants:** Covered up to \$100,000 lifetime maximum after 24 consecutive months of group health coverage or since birth. Travel/living expenses not covered for recipient's family/donor. Donor up to \$25,000 and accumulates to the \$100,000 lifetime maximum.

**Pediatric dental care** requiring general anesthesia has a \$1,000 lifetime maximum for facility if preauthorized.

**Physical, occupational, or speech therapy:** Limit of 30 visits per calendar year prescribed; 60 days for head/spinal cord injury).

**Prosthesis for organic impotency** is covered to a lifetime maximum of \$4,000. Preauthorization is required.

**Pulmonary rehabilitation** (outpatient) covered for severe chronic lung disease up to 36 visit lifetime maximum if preauthorized.

**Respite care** is covered up to 120 hours per three month period for members that require continuous assistance when arranged by the attending physician and preauthorized. Not subject to the \$20,000 hospice home care maximum.

**Routine gynecological exam** covered once each calendar year for women 18 and over. Includes Pap smear, pelvic/breast exam, blood pressure, and weight check. Includes annual mammogram for women 35 and over, or as recommended by a physician for women with a high-risk condition. Lab services are limited to occult blood, urinalysis, and complete blood count.

**Routine physicals (age 2+ years)** are covered as follows: ages 2-6 one exam every year; ages 7-18 one exam every two years; ages 19-34 one exam every four years; ages 35-59 one exam every two years; and age 60 and over one exam every year.

**Skilled nursing facility:** Covered for up to 100 days per calendar year when preauthorized by PacificSource.

**Sleep apnea** and other sleeping disorders require preauthorization. Coverage of oral devices has a \$500 lifetime maximum.

**Temporomandibular joint syndrome (TMJ)** is covered up to a \$10,000 lifetime maximum when preauthorized and medically necessary.

**Well baby care (first 24 months of life)** is limited to nine exams during first 24 months of life, including a standard in-hospital exam at birth.

**GENERAL EXCLUDED SERVICES** (see medical handbook for more complete list and details)

**Chiropractors, naturopaths, or acupuncturists**

**Cosmetic or reconstructive services**, except post-mastectomy reconstruction

**Custodial care** or daycare, including help with daily activities such as walking, bed, bathing, dressing, eating, and meals

**Dental examinations and treatment** to prevent, diagnose, or treat diseases of the teeth, tissues, or structures

**Education/training** for career, personal growth, assertiveness, sensitivity, image therapy, relaxation, stress management, parenting, family, self-help, medical equipment use, self-administered drug use, or nutrition (except for diabetic education)

**Experimental or investigational treatment**

**Eye refraction procedures, orthoptics**, vision therapy, or other services to correct refractive error

**Foot care** (routine), unless treatment is for diabetes mellitus

**Immunizations** for the purpose of travel, occupation, or foreign residence

**Impotency**, frigidity, sexual dysfunction, or sexual transformation diagnose or treatment

**Obesity or weight control** treatment or surgery, even if there are other medical reasons for weight control

**Orthognathic procedures** and over the counter medications

**Prescription drugs** and oral contraceptives (except as covered under prescription drug card) and over-the-counter medications

**Private duty nursing service**

**Treatment of any condition caused by a war**, armed invasion, or act of aggression, or while serving in the armed forces.

# SUMMARY OF BENEFITS

Douglas County



# TIERED 10/20/30 VAR PRIME HIGH Rx Group C063

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

Each time a covered pharmaceutical is dispensed, you are responsible for a copay. Copays are as follows:

<b><i>From a participating Caremark® retail pharmacy using the PacificSource Pharmacy Program (see below):</i></b>	<b><u>Tier 1: Generic</u></b>	<b><u>Tier 2: Preferred</u></b>	<b><u>Tier 3: Nonpreferred</u></b>
Up to a 34-day supply:	\$10	\$20	\$30
<b><i>From a participating mail order service (see below):</i></b>			
Up to a 45-day supply:	\$10	\$20	\$30
46 to 90-day supply:	\$20	\$40	\$60
<b><i>From a participating Caremark® pharmacy without using the PacificSource Pharmacy Program, or from a nonparticipating pharmacy (see below):</i></b>	Contracted rate minus copay or max plan allowance minus copay, whichever is less		

## 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 copay plus the difference in cost between the brand name drug and its generic equivalent.

For information on your plan's cost tiers and the preferred drug list, please see the Using Your Tiered Pharmacy Plan insert in the Additional Materials section of your Member Benefit Handbook.

## USING THE PACIFICSOURCE PHARMACY PROGRAM

The Caremark® pharmacy network includes about 98% of all retail pharmacies in the United States. It also includes *drugstore.com*, an Internet-based pharmacy service.

**To use the PacificSource pharmacy program, you must show the Caremark® plan number on your PacificSource ID card at the participating pharmacy to receive your plan's highest benefit level.** When obtaining prescription drugs at a participating Caremark® retail pharmacy, the PacificSource pharmacy program can only be accessed through the pharmacy plan number printed on your PacificSource ID card. That plan number allows the pharmacy to collect the appropriate copay from you and bill PacificSource electronically for the balance. When you use your PacificSource ID card at participating pharmacies, the pharmacy will charge you the lesser of your copay or the pharmacy's discounted drug cost plus service fee. For example, if your copay is \$10 and the drug's discounted cost plus service fee is only \$7.50, a participating pharmacy will only charge you \$7.50.

If you do not present your PacificSource ID card at the time of purchase, or if you use a nonparticipating pharmacy, you will need to file a claim for reimbursement and your benefits will be reduced. To submit a claim, send PacificSource your pharmacy receipt, your group name and number, your name and member ID number, and the patient's name and relationship to you. We will reimburse you either the contracted rate minus your copayment, or the maximum plan allowance minus your copayment, whichever is less.

### Mail Order Service

Mail order prescription service is also available through your plan for most prescription drugs. 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. For more information, please see the Mail Order Pharmacy Options for Prescription Drugs flier available from your plan administrator or PacificSource, or on the For Members area of our Web site, [www.pacificsource.com](http://www.pacificsource.com).

## OTHER COVERED PHARMACEUTICALS

Supplies covered under pharmacy are in place of, not in addition to, those same covered supplies under the medical plan. Your plan's Tier 1, Tier 2, or Tier 3 copay will apply depending on the specific prescription purchased, unless otherwise noted.

### Contraceptives

- Oral contraceptives
- Depo Provera or Lunelle injections, Ortho Evra Transdermal Patch, NuvaRing Vaginal Contraceptive Ring, or Preven.
- Diaphragm or cervical caps are available.

## **Diabetic Supplies**

- Insulin and diabetic syringes.
- Lancets and test strips.
- Glucagon recovery kits for your plan's Tier 2 copay. You 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 your 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 your Tier 2 copay. You may purchase up to two kits at one time, but no more than four kits in any calendar year (unless otherwise preauthorized).

## **CAREMARK® SPECIALTY PHARMACY PROGRAM**

Caremark® Specialty Pharmacy Services is your provider for a 30-day supply of many specialty and biotech drugs often used to treat chronic or genetic disorders. The program is designed to help PacificSource members with the following health conditions maximize the value of their health plan benefits:

Asthma	Growth hormone deficiency	Immune disorders	Pulmonary arterial hypertension
Crohn's disease	Hematopoietics	Multiple sclerosis	Pulmonary disease
Enzyme replacement	Hepatitis C	Oncology	RSV prevention
Gaucher's disease	Hormonal therapies	Psoriasis	Rheumatoid arthritis

A complete list of medications covered under this program is available on the For Members area of our Web site, [www.pacificsource.com](http://www.pacificsource.com). If you are using a covered medication, you will be contacted and invited to participate in the program. The Caremark® Specialty Pharmacy Program offers:

- Personal attention from a pharmacist-led CareTeam that provides condition-specific education, medication administration instruction, and expert advice to help you manage your therapy
- Easy access to pharmacists and other health experts 24 hours a day, seven days a week
- Easy ordering with a dedicated toll-free number
- Confidential and convenient delivery of medications to the location of your choice

## **LIMITATIONS AND EXCLUSIONS**

- This plan only covers drugs prescribed by a licensed physician (or other licensed practitioner eligible for reimbursement under your 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, smoking cessation drugs, experimental drugs, and drugs available without a prescription (even if a prescription is provided).
  - Immunizations (although certain immunizations are covered under your health plan's preventive care benefit – please see the Covered Expenses – Preventive Care Services section of your Member Benefit Handbook)
  - Viagra and other drugs and devices to treat impotency
  - 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 For Members area of our Web site, [www.pacificsource.com](http://www.pacificsource.com).
- Quantities for any drug filled or refilled are limited to no more than a 34-day supply when purchased at retail pharmacy or a 90-day supply when purchased through mail order pharmacy service.
- Quantities for Specialty Drugs are limited to no more than a 30-day supply.
- 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.
- 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%.
- Your share of the cost for prescription drugs does not apply to your medical plan's out-of-pocket maximum. Prescription drug copays are still your responsibility even if the medical plan's out-of-pocket maximum is satisfied.
- Prescription drug benefits are subject to your plan's coordination of benefits provision. (For more information, see Claims Payment–Coordination of Benefits in your Member Benefit Handbook.)