PacificSource HEALTH PLANS

Medical Benefit Summary
Balance PSN 100+0_10 GF VAR

Graduate Teaching Fellows Federation

Provider Network: University Health Center and PSN Network

Annual Deductible	Per Person, Per Contract Year	Per Family, Per Contract Year
All Providers	$100	$300
Out-of-Pocket Limit	**Per Person, Per Contract Year**	**Per Family, Per Contract Year**
Participating Providers	$1,100	N/A
Non-participating Providers	$3,300	N/A

The member is responsible for the above deductible and the following co-pays and co-insurance:

Service	UHC Participating Providers	PSN Participating Providers	Non-participating Providers
Preventive Care			
Well baby/Well child care	No charge*	No charge*	30% co-insurance
Routine physicals	No charge*	No charge*	30% co-insurance
Well woman visits	No charge*	No charge*	30% co-insurance
Routine mammograms	No charge*	No charge*	30% co-insurance
Immunizations	No charge*	No charge*	30% co-insurance
Routine colonoscopy, age 50-75	No charge*	No charge*	30% co-insurance
Professional Services			
Office and home visits	No charge*	10% co-insurance	30% co-insurance
Specialty office and home visits	No charge*	10% co-insurance	30% co-insurance
Office procedures and supplies	Covered at PSN level	10% co-insurance	30% co-insurance
Surgery	Covered at PSN level	10% co-insurance	30% co-insurance
Outpatient rehabilitation services	No charge*	10% co-insurance	30% co-insurance
Hospital Services			
Inpatient room and board	Covered at PSN level	10% co-insurance	30% co-insurance
Inpatient rehabilitation services	Covered at PSN level	10% co-insurance	30% co-insurance
Skilled nursing facility care	Covered at PSN level	10% co-insurance	30% co-insurance
Outpatient Services			
Outpatient surgery/services	Covered at PSN level	10% co-insurance	30% co-insurance
Advanced diagnostic imaging	Covered at PSN level	10% co-insurance	30% co-insurance
Diagnostic and therapeutic radiology and lab	No charge*	10% co-insurance	30% co-insurance
Urgent and Emergency Services			
Urgent care center visits	Covered at PSN level	10% co-insurance	30% co-insurance
Emergency room visits	Covered at PSN level	$50 co-pay/visit then 10% co-insurance^	$50 co-pay/visit then 30% co-insurance^
Ambulance, ground	Covered at PSN level	20% co-insurance	20% co-insurance
Ambulance, air	Covered at PSN level	20% co-insurance	20% co-insurance
Maternity Services			
Physician/Provider services (global charge)	Covered at PSN level	10% co-insurance	30% co-insurance
Hospital/Facility services	Covered at PSN level	10% co-insurance	30% co-insurance

Service	UHC Participating Providers	PSN Participating Providers	Non-participating Providers
Mental Health/Chemical Dependency Services			
Office visits	No charge*	10% co-insurance	30% co-insurance
Inpatient care	Covered at PSN level	10% co-insurance	30% co-insurance
Residential programs	Covered at PSN level	10% co-insurance	30% co-insurance
Other Covered Services			
Allergy injections	Covered at PSN level	10% co-insurance	30% co-insurance
Durable medical equipment	Covered at PSN level	10% co-insurance	30% co-insurance
Home health care	Covered at PSN level	10% co-insurance	30% co-insurance
Alternative and chiropractic	Covered at PSN level	10% co-insurance	30% co-insurance
Transplants	Covered at PSN level	No charge	40% co-insurance

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

^ **Co-pay applies to ER physician and facility charges only.** Co-pay waived if admitted into hospital. For emergency medical conditions, non-participating providers are paid at the participating provider level.

* Not subject to annual deductible.

Additional Information

What is the annual deductible?

Your plan’s deductible is the amount of money that you pay first, before your plan starts to pay. You’ll see on the Medical Benefit Summary that many services, particularly 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, individual deductibles apply only until the family deductible has been met. Deductible expense is applied to the out-of-pocket limit.

Participating provider expense and non-participating provider expense apply together toward your deductibles.

What is the out-of-pocket limit?

The out-of-pocket limit is the most you’ll pay for approved medical expenses during the plan year. Once the out-of-pocket limit has been met, the plan will pay 100% of covered charges for the rest of that year. The individual out-of-pocket limit applies only if you enroll without dependents. If you and one or more dependents enroll, individual out-of-pocket limits apply only until the family out-of-pocket limit has been met. Be sure to check your Member 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 participating and non-participating providers when it comes to meeting your out-of-pocket limit. Only participating provider expense applies to the participating provider out-of-pocket limit and only non-participating provider expense applies to the non-participating provider out-of-pocket limit.

Annual change in deductible and/or out-of-pocket limit amounts

This plan's deductible and/or out-of-pocket limit amounts may be automatically adjusted upward every January 1 based on the rules set forth by Health and Human Services (HHS).

Payments to providers

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, non-participating providers may not. Services of non-participating providers could result in out-of-pocket expense in addition to the percentage indicated.

Chiropractic Manipulation and Acupuncture Summary

Graduate Teaching Fellows Federation

This 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 co-payment and/or co-insurance 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 website, Pacificsource.com, or call our Customer Service Department.

Covered Services

- 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.
- Services of a licensed naturopath and massage therapy for medically necessary diagnosis and treatment of illness or injury.

The combined benefit for all treatments, services, and supplies provided or ordered by an alternative care provider is limited to 20 visits per person per contract year. That amount includes, but is not limited to, covered charges for any acupuncture, chiropractic manipulations and massage therapy. Laboratory services, x-rays, radiology, and durable medical equipment provided by or ordered by an alternative care provider are limited to $250 per person per contract year.

Excluded Services

- Any service or supply noted as being 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.

PacificSource HEALTH PLANS

Dental Benefit Summary
Dental Advantage Essentials

Provider Network: Dental Advantage Essentials

The member is responsible for the following co-pays.

Service	Benefit:
Office visits	$25 co-pay
Diagnostic and Preventive Services	
Routine and emergency exams	No charge
X-rays	No charge
Teeth cleaning	No charge
Fluoride treatment	No charge
Sealants	No charge
Head and neck cancer screening	No charge
Oral hygiene instruction	No charge
Periodontal charting	No charge
Periodontal evaluation	No charge
Restorative Dentistry and Prosthetics	
Fillings	No charge
Permanent crowns	$200 co-pay
Complete upper or lower denture	$150 co-pay
Bridge – per tooth	$200 co-pay
Laboratory fees	No charge
Endodontics and Periodontics	
Root canal therapy - anterior	$200 co-pay
Root canal therapy - bicuspid	$200 co-pay
Root canal therapy - molar	$200 co-pay
Osseous surgery	$200 co-pay per quadrant
Root planing	$150 co-pay per quadrant
Oral Surgery	
Routine extraction – single tooth	No charge
Surgical extraction	$150 co-pay
Orthodontia	
Pre-orthodontic service	$150 co-pay*
Comprehensive orthodontia	$3,000 co-pay
Miscellaneous	
Local anesthesia (Novocain)	No charge
Nitrous oxide	$20 co-pay
Emergency office visit	$50 co-pay
Specialty office visit	$30 co-pay
Out-of-area emergency care	Reimbursed up to $100

• Fee credited towards comprehensive orthodontic co-payment if patient accepts treatment plan. For a complete list of covered expenses, please see the Dental Fee Schedule.

Additional Information

Primary care dentist

You must select a Dental Advantage Essentials Network dentist as your primary care dentist (PCD) from the plan's provider directory. The PCD will coordinate all of your dental care needs. See your Dental Member Handbook for details.

BENEFIT LIMITATIONS – Oregon Large Employer 2014 – Dental Essentials & Dental Essentials Plus

USING THE DENTAL ADVANTAGE ESSENTIALS NETWORK

This section explains how your plan's benefits differ when you use Dental Advantage Essentials Network providers and non-participating providers. This information is not meant to prevent you from seeking treatment from any provider if you are willing to take increased financial responsibility for the charges incurred. All dental care providers are independent contractors.

PacificSource cannot be held liable for any claim or damages for injuries you experience while receiving dental care.

YOUR PRIMARY CARE DENTIST

A primary care dentist (PCD) is a Dental Advantage Essentials Network dentist for your plan who **you choose** to be responsible for your dental care. Your PCD is responsible for coordinating use of dental care resources to best meet your dental care needs.

When enrolling in this plan, you and your family members **must each select a PCD** from the plan's provider directory. Your family members may each choose a different PCD, or share the same one.

Your PCD is extremely important since the **PCD will be the first person you call** when dental care is needed. The PCD assumes primary responsibility for dental care, requests referral for more specialized services when needed, and maintains your dental records.

Once you choose a PCD, call the dentist's office to arrange for dental records to be transferred and find out how to contact your PCD after hours.

You may **change your PCD** up to twice per year by contacting PacificSource Customer Service at 541.684.5582, 888.977.9299, or cs@pacificsource.com, or by using the electronic form on our website. The change will be **effective** on the first of the month after we receive your request. All current specialist referrals from your former PCD will become invalid and you will need to request new referrals from your new PCD.

REFERRALS

When you and your PCD decide that services of a specialist are necessary, your PCD will contact the appropriate referral management coordinator and request that you be referred to a Dental Advantage Essentials Network specialist. If the referral is approved, you may see the specialist designated on the referral authorization. The referral authorization will specify which services may be performed by the specialist.

NON-PARTICIPATING PROVIDERS

This plan does not cover services of a non-participating provider, except in emergency situations (see below.)

EMERGENCY CARE

Your PCD is responsible for providing and arranging all your dental care, including emergency care whenever possible. In emergency situations, your PCD should be contacted within 24 hours of the occurrence, or as soon as reasonably possible, to begin coordinating your dental care.

Emergency care is care which cannot be delayed due to injury or sudden illness, when a delay for the time required to reach a PCD would mean risking permanent damage to the patient's health. Examples of dental emergencies include:

- Unusual or excessive bleeding;
- Infection that causes difficulty breathing; or
- A tooth that has been knocked out.

Routine dental care, such as cavities, broken teeth, and non-emergent dental problems, are not considered dental emergencies.

- Out-of-area coverage is provided only for true dental emergencies. Routine dental services are not covered when rendered outside the service area. This plan covers out-of-area emergency expense only if:
- The need for emergency services could not be anticipated before leaving the service area; Delay in obtaining emergency services until the enrollee returns to the service area would endanger the enrollee's life or health;
- Your PCD is notified within 24 hours of the dental emergency or as soon thereafter as reasonably possible; and

Emergency services are dentally necessary.

This plan does not provide emergency benefits for follow-up care. Benefits for out-of-area emergencies are limited to usual, customary, and reasonable charges.

FINDING DENTAL ADVANTAGE ESSENTIALS NETWORK PROVIDER INFORMATION

You can find up-to-date Dental Advantage Essentials Network provider information:

- By asking your dental care provider if he or she is a Dental Advantage Essentials Network provider for PacificSource dental plans.
- On the PacificSource website, PacificSource.com. Simply click on 'Find a Provider' under 'Find a Provider or Drug' and you can easily look up Dental Advantage Essentials Network providers or print your own customized directory.
- By contacting the PacificSource Customer Service Department. Our staff can answer your questions about specific providers. If you'd like a complete provider directory for your plan, just ask--we'll be glad to mail you a directory free of charge.

CO-PAY SCHEDULE

Details on covered services and co-pays can be found on the Dental Fee Schedule. You are responsible for the applicable office visit co-pay shown on the Dental Fee Schedule each time you seek services or supplies from a Dental Advantage Essentials Network dentist.

BENEFIT AND LIMITATIONS

Teeth cleaning frequency is determined at your first visit with a Dental Advantage Essential Network dentist.

A Dental Advantage Essentials Network dentist will make this determination based on what is dentally necessary. Frequency of other services is also determined by the Dental Advantage Essentials Network dentist based on what is dentally necessary.

BENEFIT EXCLUSIONS – Oregon Large Employer 2014 – Dental Essentials & Dental Essentials Plus

This plan does not provide benefits in any of the following circumstances or for any of the following conditions:

- **Aesthetic dental procedures-**Services and supplies for dental procedures that are aesthetic such as bleaching of teeth and labial veneers.
- **Antimicrobial agents-**Localized delivery of antimicrobial agents into diseased crevicular tissue via a controlled release vehicle.
- **Athletic activities-**Any injuries sustained while competing or practicing for a professional or semiprofessional athletic contest.
- **Athletic mouth guards**.
- **Benefits not stated-**Services and supplies not described as covered under this plan, except essential health benefits defined by the ACA.
- **Biopsies or histopathologic exams-**A separate charge for a biopsy of oral tissue or histopathologic exam
- **Bone replacement grafts** to prepare sockets for implants after tooth extraction.
- Charges for **broken appointments**.
- **Collection of cultures and specimens**.
- **Connector bar or stress breaker**.
- **Core build-ups** are not covered unless used to restore a tooth that has been treated endodontically (root canal).
- **Cosmetic/reconstructive services and supplies-**Procedures, appliances, restorations, or services for cosmetic purposes. Includes services or supplies to correct congenital or developmental malformations such as peg laterals, cleft palate, maxillary and mandibular (upper and lower jaw) malformation, enamel hypoplasia, veneers, and fluorosis. Replacement of congenitally missing teeth is covered.
- **Denture replacement** made necessary by loss, theft, or breakage.
- **Diagnostic casts-**Study models), gnathological recordings, occlusal appliances, occlusal equilibration procedures, or similar procedures.
- Prescribed, premedication, analgesics, other euphoric **drugs or medications**, or take-home medicine or supplies distributed by a provider.
- **Educational programs-**Instructions and/or training in plaque control and oral hygiene.
- **Experimental or investigational-**Service, supply, protocol, procedure, device, drug or medicine, or use thereof that is experimental or investigational for diagnosis or treatment. An experimental or investigational service is not made eligible by the fact that the dental provider considers other treatment to be ineffective or not as effective as the service or that it is prescribed as the most likely to prolong life.
- **Fractures of the mandible-**Services and supplies in connection with the treatment of simple or compound fractures of the mandible.
- **General anesthesia** except when administered by a dentist in connection with oral surgery in his/her office.
- **Gingivectomy, gingivoplasty or crown lengthening** in for crown preparation or fixed bridge services done on the same date of service.
- **Hospital charges** or additional fees charged by the dentist for hospital treatment. Services may be provided in a hospital or other facility only when a hospital setting is dentally necessary and the services are preauthorized by the Dental Advantage Essentials Network dentist.
- **Hypnosis.**
- **Indirect pulp caps** are to be included in the restoration process, and are not a separate covered benefit.
- **Infection control-**A separate charge for infection control or sterilization.
- **Intra and extra coronal splinting-**Devices and procedures for intra and extra coronal splinting to stabilize mobile teeth.
- **Oral surgery treating any fractured jaw**.
- **Orthodontic services-**Repair or replacement of orthodontic appliances furnished under this plan.
- **Orthodontic services-**Treatment of malalignment of teeth and/or jaws, or ancillary services performed because of orthodontic treatment.
- **Orthognathic surgery-**Surgery to manipulate facial bones or the jaw in patients with facial bone abnormalities performed to restore the proper anatomic and functional relationship to the facial bones.
- **Photographic images**.
- **Precision attachments**.
- **Pulpotomies on permanent teeth**.
- **Removal of clinically serviceable amalgam restorations** to be replaced by materials free of mercury, unless proof of allergy to mercury.
- **Services covered by the member's medical plan**.
- **Services for rebuilding or maintaining chewing surfaces** due to teeth out of alignment or occlusion, or for stabilizing the teeth.
- **Services otherwise available-**Includes but not limited to: Services or supplies that payment could be obtained in whole or in part if the member applied for payment under a city, county, state, or federal law (except Medicaid), or that the member could have received in a hospital or program operated by a federal government agency or authority. Covered services or supplies furnished by the Veterans' Administration of the United States that are not service-related are eligible for payment, or that payment would be made by Medicare.
- **Services or supplies that no charge is made**, you are not legally required to pay, or a provider or facility is not licensed to provide even though the service or supply may otherwise be eligible. This includes services provided by you or an immediate family member.
- **Services or supplies provided outside of the United States**, except in cases of emergency.
- **Sinus lift grafts** to prepare sinus site for implants.
- **Stress-breaking or habit-breaking appliances**.
- **Temporomandibular joint-**Services or supplies for treatment of any disturbance of the temporomandibular joint.
- **Third party or motor vehicle liability, motor vehicle insurance coverage, workers' compensation-**Services or supplies for illness or injury that a third party is responsible or are payable by such third party or are payable pursuant to applicable workers' compensation laws, motor vehicle liability, uninsured or underinsured motorist, and personal injury protection insurance and any other liability and voluntary medical payment insurance to the extent of any recovery received from or on behalf of such sources.
- **Tooth transplantation-**Services and supplies in connection with tooth transplantation, including re-implantation from one site to another and splinting and/or stabilization. Exclusion does not relate to the re-implantation of a tooth into its original socket after it is avulsed.
- **Treatment after insurance ends-**Services or supplies provided after enrollment in this plan ends, except as provided for under Extension of Benefits. The only exception is Class III Services ordered and fitted before enrollment ends and placed within 31 days after enrollment ends.
- **Treatment not dentally necessary** according to acceptable dental practice or treatment not likely to have a reasonably favorable prognosis.
- **Treatment prior to enrollment-**Dental services begun before you or your family member became eligible for those services under this plan.
- **Treatment while incarcerated-**Services or supplies received while in custody of a state or federal law enforcement authority, jail, or prison.
- **Unwilling to release information-**Services or supplies that you are unwilling to release dental information necessary to determine eligibility.
- **War-related-**Treatment of a condition caused by or arising out of an act of war, armed invasion, or aggression, or while in the armed forces.
- **Work-related conditions-**Services or supplies for treatment of illness or injury arising out of or in the course of employment or self-employment for wages or profit, whether or not the expense for the service or supply is paid under workers' compensation.

PacificSource HEALTH PLANS

Prescription Drug Benefit Summary
Rx 30% VAR

Graduate Teaching Fellows Federation

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

The amount you pay for covered prescriptions at participating pharmacies applies toward your plan's participating medical out-of-pocket limit, shown on the Medical Benefit Summary. The co-payment and/or co-insurance for prescription drugs obtained from a participating pharmacy are waived during the remainder of a contract year in which you have satisfied the medical out-of-pocket limit.

Each time a covered pharmaceutical is dispensed, you are responsible for the co-payment and/or co-insurance below:

	Tier 1: Generic	Tier 2: Preferred>	Tier 3: Non-preferred>
Participating Retail Pharmacy^			
Up to a 30 day supply:	30% co-insurance*	30% co-insurance*	30% co-insurance*
Non-participating Pharmacy			
Regardless of tier or day(s) supply:	50% co-insurance per prescription*		
Specialty Drugs – Participating Specialty Pharmacy			
Up to a 30 day supply:	The lesser of 30% co-insurance per prescription or $300 co-pay per prescription*		
Specialty Drugs – Not filled through Participating Specialty Pharmacy			
Regardless of tier or day(s) supply:	50% co-insurance per prescription*		

* *Not subject to annual deductible.*
^ *Remember to show your PacificSource ID Card each time you fill a prescription at a retail pharmacy.*
> *MAC C - Regardless of the reason or medical necessity, if you receive a brand name drug or if your physician prescribes a brand name drug when a generic is available, you will be responsible for the brand name drug's co-payment and/or co-insurance.*

See your member handbook for important information about your prescription drug benefit, including which drugs are covered, how the tiers work, limitations and more.

PacificSource HEALTH PLANS

Vision Benefit Summary
Vision Plus VAR

Graduate Teaching Fellows Federation

The following shows the vision benefit available under this plan for enrolled members for all vision exams, lenses, and frames furnished during any contract year when performed or prescribed by a licensed ophthalmologist or licensed optometrist.

If charges for a service or supply are less than the amount allowed, the benefit will be equal to the actual charge. If charges for a service or supply are greater than the amount allowed, the expense above the allowed amount is the member's responsibility.

Member Responsibility

Service/Supply	Participating Providers	Non-Participating Providers
Enrolled Members Through Age 18		
Eye Exam	No charge*	No charge* up to $40 maximum then 100% co-insurance
Vision Hardware	No charge* for one pair per year for non-collection frames and/or lenses	No charge* for one pair per year up to $75 then 100% co-insurance for non-collection frames and/or lenses
Enrolled Members Age 19 and Older		
Eye Exam	$10 co-pay*	No charge* up to $50 maximum then 100% co-insurance
Single vision	No charge*	No charge* up to $56 maximum then 100% co-insurance
Bifocal	No charge*	No charge* up to $84 maximum then 100% co-insurance
Trifocal	No charge*	No charge* up to $116 maximum then 100% co-insurance
Lenticular	No charge*	No charge* up to $236 maximum then 100% co-insurance
Progressive	No charge* up to $100 maximum then 100% co-insurance	No charge* up to $100 maximum then 100% co-insurance
Frames	$25 co-pay* up to $150 maximum then 100% co-insurance	$25 co-pay* up to $70 maximum then 100% co-insurance
Contacts (in place of glasses)	No charge* up to $200 maximum then 100% co-insurance	No charge* up to $200 maximum then 100% co-insurance

* Not subject to annual deductible.

Benefit Limitations: enrolled members through age 18

'Collection' lenses and/or frames refers to brand name hardware when comparable non-brand/non-collection lenses and/or frames are available. Collection glasses (lenses and frames) are not covered.

- One vision exam every contract year
- One pair of non-collection glasses (lenses and frames) per contract year. If the cost of the frame is over $175, preauthorization by PacificSource is required.
- In lieu of eyeglasses, elective contact lens services and materials are covered in full with the following limitations per contract year:
  - Standard = 1 contact lens per eye (total 2 lenses); OR
  - Monthly = 6 lenses per eye (total 12 lenses); OR

- Bi-weekly = 6 lenses per eye (total 12 lenses); OR
- Dailies = 30 lenses per eye (total 60 lenses).

Benefit Limitations: enrolled members age 19 and older

- Vision exam: One vision exam every contract year
- Lenses: One pair every contract year
- Frames: Once every contract year
- Contact lenses: Once every contract
- **Elective contact lenses are in lieu of frames and lenses**

Exclusions

- 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 coating 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
- Eye exams required as a condition of employment, required by a labor agreement or government body
- Expenses covered under any worker's compensation law
- Services or supplies received before this plan's coverage begins or after it ends
- Charges for services or supplies covered in whole or in part under any medical or vision benefits provided by the employer
- Medical or surgical treatment of the eye
- Visual field charting
- Lenticular lenses
- Aniseikonic lenses
- More than the allowance for a standard lens when multi-focal hard resin lenses or no-line bifocals (blended) are chosen
- Charges for more than on exam, two lenses, and one frame per person in any contract year. Contact charges for more than the allowance for singe vision lenses and frames.

Important information about your vision benefits

Your PacificSource group health plan 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 and 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 non-participating 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 non-participating provider benefits.