Lane Community College

BENEFITS SUMMARY

Management
July 1, 2011

Medical, Vision and Prescription coverage provided by PacificSource Health Plans

Medical: PacificSource Preferred Provider Option (PPO) plan. **To receive maximum benefits, it is important to use In-Network PPO providers.** In-Network benefits include an annual deductible of $500 per person, or $1,250 for family coverage, with an annual out-of-pocket maximum of $1,500 per person. In-Network office visits have a $25 co-payment. Out-of-Network benefits include an annual deductible of $1,000 per person, or $2,500 for family coverage, with an annual out-of-pocket maximum of $2,250 per person. Out-of-Network office visits are charged at 40% after deductible. A list of in-network providers included in the Preferred PSN plan can be accessed online at www.pacificsource.com.

Vision: In-Network benefits include one eye exam every calendar year paid at 100%. Out-of-Network benefits include one eye exam every calendar year paid at 100%, up to a maximum of $64.50.

Dental Coverage Provided by Oregon Dental Service (ODS) or Willamette Dental

ODS Coverage: Preventative services are paid at 100%; restorative services are paid at 80% after a $25 deductible; major services are paid at 60% after a $25 deductible. Annual maximum benefit is $2000 in paid benefits (by ODS) per member per calendar year. No orthodontia coverage.

Willamette Dental Coverage: Preventative, restorative and major services are paid at 100% after a $10 office visit co-payment. No annual maximum benefit applies. Orthodontia coverage is paid at 100% after a one-time $1500 orthodontia co-payment and a $10 office co-payment per visit.

Monthly Contribution Summary for Medical, Vision and Dental Insurance

Employee pre-tax payroll deduction for PacificSource Medical, Vision & Rx with

Coverage Level	ODS Dental	Willamette Dental
Employee Only Coverage	$8.87	$0.00
Employee + 1 Coverage	$121.34	$99.81
Full Family Coverage	$154.93	$119.93

Employer contribution for PacificSource Medical, Vision & Rx with

Coverage Level	ODS Dental	Willamette Dental
Employee Only Coverage	$685.99	$683.21
Employee + 1 Coverage	$1,452.46	$1,452.46
Full Family Coverage	$1,819.05	$1,819.05

Carrier Contact Information

PacificSource.....(541) 684-5582 .....(888) 977-9299

Oregon Dental Service.....(503) 265-2965 .....(888) 217-2365

Willamette Dental.....(800) 460-7644 customer service.....(800) 461-8994 appointments

OEA Choice Trust (Section 125).....(503) 620-3822 .....(800) 452-0914

Management Benefit Plan Summary

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.

The annual deductible has changed for 2011-12 plan year

Medical/Vision Insurance

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

* Expenses applied toward the annual deductible do not apply to the out-of-pocket maximum.

** Subject to state-mandated limitations.

*** All services are subject to the plan's maximum plan allowance for those services.

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)	$30 co-pay	$60 co-pay	$100 co-pay
Individual out-of-pocket maximum per calendar year	$750 (separate from medical)		

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
www.wellpartner.com	www.caremark.com

Vision Benefit **PacificSource Preferred PSN Plan**	**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	

Mental Illness/Chemical Dependency (including alcoholism) Subject to State Mandates	**Adult Benefit** (during any 2 calendar year period)	**Child Benefit** (during any 2 calendar year period)
Mental Health*		
Residential	19 days	21 days
Inpatient	16 days	17 days
Chemical Dependency*		
Residential	21 days	30 days
Inpatient	14 days	32 days

* Must be pre-authorized and referred by the PacificSource Mental Health/Chemical Dependency Program Coordinator.

Dental Insurance
Plan Options

Dental Benefits	Oregon Dental Service (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 met[1]	100%*[2]
Simple Tooth Extractions	80% after deductible met	100%*
Surgical tooth extractions, including diagnosis and evaluation	80% after deductible met	100%*
Diagnosis, evaluation, and treatment of gum disease including scaling and root planing	80% after deductible met	100%*
Root canal and related therapy including diagnosis and evaluation	80% after deductible met	100%*
Major Restorative Services - Class III		
Gold or porcelain crowns	60% after deductible met[1]	100%*
Full and partial dentures	60% after deductible met	100%*
Bridge retainers and pontics	60% after deductible met	100%*

Orthodontics	Not covered	$1,500 co-pay + $10 per visit**

Under ODS plans, 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.

Underwritten by Oregon Dental Service

This plan provides extensive coverage of services and supplies to prevent, diagnose, and treat diseases or conditions of the teeth and supporting tissues. Presented are just some of the most common procedures covered in your plan. This is a summary only. Please see the Certificate of Coverage for a complete plan description, limitations, and exclusions.