PACIFIC STATES MARINE FISHERIES COMMISSION
BENEFITS AT A GLANCE
EFFECTIVE JANUARY 1, 2008

This summary does not contain all of the provisions or limitations which apply to your Medical, Prescription Drugs, Vision, and Dental coverages. For coverage details, see your benefit booklet. Upon receipt of your benefit booklet, please discard this summary, as benefits are subject to change.

MEDICAL EXPENSE COVERAGE

	PPO PROVIDER	NON-PPO PROVIDER
Lifetime Maximum Payment Limit	$2,000,000	
Calendar Year Deductible Per Person Per Family	 $ 300 $ 900	
You pay one individual Deductible Amount each calendar year. For satisfaction of the family Deductible Amount, no more than one individual Deductible Amount will apply for any one person. After you satisfy the Deductible, Comprehensive Medical benefits will be payable for Covered Charges at the rate of payment shown below. The Copayments shown below: • will not count toward satisfaction of the Deductible; and • will continue to apply after the Out-of-Pocket Expense limit and the Deductible are reached.		
Out-of-Pocket Maximums* (Amounts include Deductible) Per Person	$ 2,500	$ 5,000
If the amount you pay for Covered Charges in any one calendar year reaches the Out-of-Pocket Expense Maximum shown above, Comprehensive Medical benefits payable will be 100% of additional Covered Charges (except as described below). The amounts that DO NOT apply toward your Out-of-Pocket Expense Maximum are: • Copayments; and • the amount you must pay because of penalty charges for failure to comply with Utilization Management Requirements as described below; and • non-covered charges including but not limited to any part of a charge for Treatment or Service that exceeds Prevailing Charges. *PPO and Non-PPO Out-of-Pocket Maximums do reduce each other.		

SERVICE	PPO PROVIDER	NON-PPO PROVIDER
Physician Visit Charges	You pay Deductible, then plan pays 90%	You pay Deductible, then plan pays 70%
Preventive Care • Routine Physical Exams • Routine Gynecological Exams • Prostate Exams • PSA Tests • Mammograms • Well Child Care • Immunizations • X-Ray and Lab services provided during the exam	Plan pays 90% (Deductible waived)	Plan pays 90% (Deductible waived)
Well Newborn Inpatient Hospital Care	Plan pays 90% (Deductible waived)	Plan pays 70% (Deductible waived)

SERVICE	PPO PROVIDER	NON-PPO PROVIDER
Inpatient Hospital Care	You pay Deductible, then plan pays 90%	You pay Deductible, then plan pays 70%
Outpatient Hospital Care	You pay Deductible, then plan pays 90%	You pay Deductible, then plan pays 70%
X-Ray and Laboratory Services	You pay Deductible, then plan pays 90%	You pay Deductible, then plan pays 70%
Emergency Room Services for Medical Emergency	You pay $25 Copay, then plan pays 90% (Deductible waived)	You pay $25 Copay, then plan pays 70% (Deductible waived)
Emergency Room Services for non-Medical Emergency	You pay $150 Copay, then plan pays 90% (Deductible waived)	You pay $150 Copay, then plan pays 70% (Deductible waived)
Ambulance	You pay Deductible, then plan pays 80%	You pay Deductible, then plan pays 80%
Chiropractic Services By Any Physician	You pay Deductible, then plan pays 90%	You pay Deductible, then plan pays 70%
Massage Therapy, Naturopathic Care, & Acupuncture/Acupressure	You pay Deductible, then plan pays 80%	You pay Deductible, then plan pays 80%
Chiropractic services, massage therapy, naturopathic care, & acupuncture/acupressure are limited to a combined maximum of 40 visits per calendar year. These services are not subject to Medically Necessary Care requirements.		
Home Health Care Limited to 100 visits per calendar year	You pay Deductible, then plan pays 90%	You pay Deductible, then plan pays 70%
Hospice Care Limited to $10,000 per episode	You pay Deductible, then plan pays 90%	You pay Deductible, then plan pays 70%
Skilled Nursing Facility Care Limited to $800 per day and 120 days for the same or related condition	You pay Deductible, then plan pays 90%	You pay Deductible, then plan pays 70%
Mental or Nervous Disorders		
Inpatient Treatment Limited to 30 days per calendar year	You pay Deductible, then plan pays 90%	You pay Deductible, then plan pays 70%
Outpatient Treatment No limit	You pay Deductible, then plan pays 90%	You pay Deductible, then plan pays 70%
Alcoholism or Drug Abuse		
Inpatient Treatment Limited to 30 days per calendar year	You pay Deductible, then plan pays 90%	You pay Deductible, then plan pays 70%
Outpatient Treatment No limit	You pay Deductible, then plan pays 90%	You pay Deductible, then plan pays 70%
Hearing Aids Limited to $1,000 per person per calendar year	Plan pays 100% (Deductible waived)	Plan pays 100% (Deductible waived)
All Other Covered Charges	You pay Deductible, then plan pays 90%	You pay Deductible, then plan pays 70%

SERVICE	WITHIN THE TRANSPLANT NETWORK	OUTSIDE THE TRANSPLANT NETWORK
Transplant Services See page GH 400 in your benefit booklet for a more complete description of benefits for transplant services	100% (Deductible waived)	You pay Deductible, then plan pays 60%
Travel and lodging benefits for services provided by a provider in the Transplant Network will be payable at 100% of Covered Charges up to a maximum of $10,000 for each approved transplant. No benefits will be payable for travel and lodging expenses if services are provided outside the Transplant Network.		

Medical Emergency

If you or one of your Dependents requires treatment for a Medical Emergency and cannot reasonably reach a PPO Provider, benefits for such treatment received will be paid at the same level as a PPO Provider.

Uncontrollable Providers

For emergency room Physician charges, anesthesiology, radiology, and pathology services provided by a Non-PPO Provider, benefits will be payable at the PPO level when such services are provided at a PPO Hospital (inpatient, outpatient, and Hospital emergency room) or a licensed PPO freestanding surgical center.

Out-of-Area

If you or one of your Dependents reside 30 miles or more from a PPO Provider, Covered Charges will be payable at the PPO Provider level of benefits. This requires enrollment in the Out-of-Area plan and is not automatic. If you believe this applies to you or one of your Dependents, please contact your employer's Human Resources department.

UTILIZATION MANAGEMENT REQUIREMENTS

A **Hospital Admission Review** must be obtained for Hospital Inpatient Confinements and certain surgical procedures. You must obtain a Hospital Admission Review prior to, but no later than, the day of admission to a Hospital (for other than a Medical Emergency); and for a Medical Emergency, within two working days following a Hospital admission or as soon as reasonably possible thereafter. Failure to comply with the Hospital Admission Review requirements will result in benefits being reduced by 25% per confinement. The 25% reduction in Benefits Payable will not count toward satisfaction of the Out-of-Pocket Expense limits and will not exceed $2,000 per individual each calendar year. Your medical ID card gives a toll-free telephone number to call for Hospital reviews.

If you use the PPO, your PPO Physician automatically handles Hospital Admission Review.

PRESCRIPTION DRUGS		
	RETAIL DRUGS	**MAIL ORDER DRUGS**
Generic & Brand Name Drugs Copayments do not apply to the Out-of-Pocket Maximums.	30% Copayment for each prescription	30% Copayment for each prescription
Maximum Supply	90 days for each prescription	90 days for each prescription

VISION CARE	
Calendar Year Deductible Per Person	$25
Maximum Payment Limit Per Person	$350 per calendar year

Plan pays 100% of Covered Charges in excess of the Deductible, up to the Maximum Payment Limit for:

- Complete Visual Analysis
- Single Lenses
- Bifocal Lenses
- Trifocal Lenses
- Lenticular Lenses
- Frames
- Contact and VDT (Video Display Terminal) Lenses
- Laser Surgery for Refractive Correction
- Any glasses prescribed by a Physician

DENTAL EXPENSE COVERAGE	
Calendar Year Deductible Basic & Major Procedures combined Per Person	$25
Maximum Payment Limits Preventive, Basic, & Major Procedures (combined) Orthodontia	$1,500 per person per calendar year $1,000 per person per lifetime
Procedure Categories Preventive Basic Major Orthodontia	 100% (not subject to Deductible) 80% 50% 50% (not subject to Deductible)

Dental Treatment Plan

When charges for a Period of Dental Treatment (other than Emergency Treatment) are expected to exceed $300, it is strongly recommended that you file a Dental Treatment Plan with the Claims Administrator before treatment begins.