PacificSource HEALTH PLANS

Medical Benefit Summary
Navigator 100+10_10 S3

West Linn Wilsonville School District – Classified

Benefit Year: Calendar Year

Provider Network: Navigator

Deductible Per Benefit Year	In-network and Out-of-network	
Individual/Family	$100/$200	
Out-of-Pocket Limit Per Benefit Year	**In-network**	**Out-of-network**
Individual/Family	$3,000/$6,000	Not applicable

Note: In-network out-of-pocket limit accumulates separately from the out-of-network out-of-pocket limit. Even though you may have the same benefit for in-network and out-of-network, your actual costs for services provided out-of-network may exceed this plan's out-of-pocket limit for out-of-network services. In addition, out-of-network providers may in certain circumstances bill you for the difference between the amount charged by the provider and the amount allowed by the insurance company (called balance billing). Balance billing amounts are not counted toward the out-of-network out-of-pocket limit. For additional information about balance billing or allowable fees, see your handbook.

The member is responsible for any amounts shown above, in addition to the following amounts:

Service/Supply	In-network Member Pays	Out-of-network Member Pays
Preventive Care		
Well baby/Well child care	No deductible, 0%	After deductible, 90%
Preventive physicals	No deductible, 0%	After deductible, 90%
Well woman visits	No deductible, 0%	After deductible, 90%
Preventive mammograms	No deductible, 0%	After deductible, 90%
Immunizations	No deductible, 0%	After deductible, 90%
Preventive colonoscopy	No deductible, 0%	After deductible, 90%
Prostate cancer screening	No deductible, 0%	After deductible, 90%
Professional Services		
Office and home visits	First three visits no deductible, $5. Subsequent visits, no deductible, $10*	After deductible, 90%
Naturopath office visits	No deductible, $10	After deductible, 90%

Service/Supply	In-network Member Pays	Out-of-network Member Pays
Specialist office and home visits	No deductible, $10	After deductible, 90%
Telehealth visits	First three visits no deductible, $5. Subsequent visits, no deductible, $10*	After deductible, 90%
Office procedures and supplies	After deductible, 10%	After deductible, 90%
Surgery	After deductible, 10%	After deductible, 90%
Outpatient rehabilitation and habilitation services	No deductible, $10	After deductible, 90%
Acupuncture (12 visits per benefit year)	No deductible, $15	After deductible, 90%
Chiropractic manipulation/Spinal manipulation (20 visits per benefit year)	No deductible, $15	After deductible, 90%
Massage therapy ($500 per benefit year)	No deductible, $25	After deductible, 90%
Hospital Services		
Inpatient room and board	No deductible, $200/day>	After deductible, 90%
Inpatient rehabilitation and habilitation services	After deductible, 10%	After deductible, 90%
Skilled nursing facility care	After deductible, 10%	After deductible, 90%
Outpatient Services		
Outpatient surgery/services	No deductible, $200/visit	After deductible, 90%
Diagnostic imaging – advanced	After deductible, 10%	After deductible, 90%
Diagnostic and therapeutic radiology/laboratory and dialysis – non-advanced	After deductible, 10%	After deductible, 90%
Urgent and Emergency Services		
Urgent care center visits	No deductible, $35	After deductible, 90%
Emergency room visits – medical emergency	No deductible, $150^	No deductible, $150^
Emergency room visits – non-emergency	No deductible, $150^	After deductible, 90%
Ambulance, ground	After deductible, 30%	After deductible, 30%

Service/Supply	In-network Member Pays	Out-of-network Member Pays
Ambulance, air	After deductible, 30%	After deductible, 30%
Maternity Services**		
Physician/Provider services (global charge)	No deductible, $100 per pregnancy	After deductible, 90%
Hospital/Facility services	No deductible, $200/day>	After deductible, 90%
Mental Health and Substance Use Disorder Services		
Office visits	First three visits no deductible, $5. Subsequent visits, no deductible, $10*	After deductible, 90%
Inpatient care	No deductible, $200/day>	After deductible, 90%
Residential programs	No deductible, $200/day>	After deductible, 90%
Other Covered Services		
Allergy injections	After deductible, 10%	After deductible, 90%
Durable medical equipment	After deductible, 30%	After deductible, 90%
Home health services	After deductible, 10%	After deductible, 90%
Transplants	After deductible, 10%	After deductible, 90%
Infertility	After deductible, 60%	After deductible, 90%
Temporomandibular joint	After deductible, 60%	After deductible, 90%

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

^ Copay applies to ER physician and facility charges only. Copay waived if admitted into hospital.

*First 3 visits per benefit year combined for Professional Services – Office and home visits, Telehealth visits, and Mental Health and Substance Use Disorder Services – Office visits.

** Medically necessary services, medication, and supplies to manage diabetes during pregnancy from conception through six weeks postpartum will not be subject to a deductible, copayment, or coinsurance.

Additional information

What is the deductible?

Your plan's deductible is the amount of money that you pay first, before your plan starts to pay. You'll see that many services, especially 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, the individual deductible applies for each member only until the family deductible has been met.

In-network expense and out-of-network expense apply together toward your deductible.

What is the out-of-pocket limit?

The out-of-pocket limit is the most you'll pay for covered services during the benefit year. Once the out-of-pocket limit has been met, the plan will pay 100 percent of allowed amounts for covered services for the rest of that benefit year. The individual out-of-pocket limit applies only if you enroll without dependents. If you and one or more dependents enroll, the individual out-of-pocket limit applies for each member only until the family out-of-pocket limit has been met. Be sure to check your 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 in-network and out-of-network when it comes to meeting your out-of-pocket limit.

Payments to providers

Payment to providers is based on the prevailing or allowable fee for covered services. In-network providers accept the allowable fee as payment in full. Services of out-of-network providers could result in out-of-pocket expense in addition to the percentage indicated.

Prior authorization

Coverage of certain medical services and surgical procedures requires a benefit determination by PacificSource before the services are performed. This process is called prior authorization. Prior authorization is necessary to determine if certain services and supplies are covered under this plan, and if you meet the plan's eligibility requirements. Prior authorization does not change your out-of-pocket expense for in-network and out-of-network providers. You can search for procedures and services that require prior authorization on our website, Authgrid.PacificSource.com (select Commercial for the line of business).

Discrimination is against the law

PacificSource Health Plans complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. PacificSource does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.