West Linn Wilsonville School District #3Jt

Administration / Confidential Medical Plan Options

Effective 12/1/2022

Plan Name	PacificSource Navigator 200_10 S3, $5-10-25 1000 OP Rx, Vision Plus, Alt Care		PacificSource Navigator 100+5_10 S3, $5-10-25 1000 OP Rx, Vision Plus, Alt Care		PacificSource Navigator 1600_30+Rx Non-embedded S3, Vision Plus, Alt Care	
Plan Info	**In Network**	**Out of Network**	**In Network**	**Out of Network**	**In Network**	**Out of Network**
Annual Deductible/Individual	$200		$100		$1,600	$3,200
Annual Deductible/Family	$400		$200		$3,200	$6,400
Annual Out-of-Pocket Maximum/Individual	$1,600		$1,000	NA	$3,500	$10,500
Annual Out-of-Pocket Maximum/Family	$3,200		$2,000	NA	$7,000	$21,000
General Services	**Member pays after Deductible (Deductible is waived when noted by *)**					
Preventive Services	Covered in Full*	40%*	Covered in Full*	90%	Covered in Full*	50%*
Office Visit	10%	40%	$5 Copay*	90%	30%	50%
Specialist Visit	10%	40%	$5 Copay*	90%	30%	50%
Naturopaths	10%	40%	$5 Copay*	90%	30%	50%
Diagnostic & Therapeutic Radiology/Lab	10%	40%	10%	90%	30%	50%
Advanced Diagnostic Imaging	10%	40%	10%	90%	30%	50%
Urgent Care	10%	10%	$35 Copay*	90%	30%	50%
Hospital Services						
Inpatient Hospitalization	10%	40%	10%	90%	30%	50%
Outpatient Surgery	10%	40%	10%	90%	25% Ambulatory Surgery Center 30% Hospital-Based	50%
Emergency Room	10%	10%	$150 Copay / visit, 10%*		30%	30%
Ambulance (Ground/Air)	30%	30%	30%	30%	30%	30%
Alternative Care						
Chiropractic Manipulation (20 visit limit)	$15 Copay / visit*	40%	$15 Copay / visit*	90%	30%	50%
Acupuncture (12 visit limit)	$15 Copay / visit*	40%	$15 Copay / visit*	90%	30%	50%
Massage Therapy ($500 limit)	$25 Copay / visit*	40%	$25 Copay / visit*	90%	30%	50%
Prescription Drug Benefits	**$1,000 Out of Pocket Maximum ($2,000 Family)**		**$1,000 Out of Pocket Maximum ($2,000 Family)**		**Combined Medical/Rx Deductible & Out of Pocket**	
PacificSource Expanded No Cost Rx:	No Cost at In Network Pharmacy		No Cost at In Network Pharmacy		No Cost at In Network Pharmacy	
At Retail: (Maximum Day Supply)	Up to a 90 day supply	Up to a 30 day supply	Up to a 90 day supply	Up to a 30 day supply	Up to a 90 day supply	Up to a 30 day supply
Tier 1 (Per 30 day supply)	$5 Copay*	90%*	$5 Copay*	90%*	20%	90%
Tier 2 (Per 30 day supply)	$10 Copay*	90%*	$10 Copay*	90%*	20%	90%
Tier 3 (Per 30 day supply)	$25 Copay*	90%*	$25 Copay*	90%*	20%	90%
Tier 4 (Per 30 day supply)	Lesser of $150 or 10%*	90%*	Lesser of $150 or 10%*	90%*	20%	90%
Compound Drugs - (30 day max)	$25 Copay*	90%*	$25 Copay*	90%*	20%	90%
Mail Order: (Maximum Day Supply)	Up to a 90 day supply		Up to a 90 day supply		Up to a 90 day supply	
Tier 1 (Per 90 day supply)	$10 Copay*		$10 Copay*		20%	
Tier 2 (Per 90 day supply)	$20 Copay*	NA	$20 Copay*	NA	20%	NA
Tier 3 (Per 90 day supply)	$50 Copay*		$50 Copay*		20%	
Tier 4 (Per 90 day supply)	Lesser of $300 or 10%*		Lesser of $300 or 10%*		20%	

Vision	In Network	Out of Network
Exam (Every 12 months)	$10 Copay*	Reimbursed up to $40*
Lenses (Every 12 months)	$10 Copay* ($75 Copay for Standard Progressives)	Reimbursement varies $40 - $80*
Frames (Every 12 months)	$150 allowance*	Reimbursed up to $45*
Contact Lenses in Lieu of Glasses (Every 12 months)	$120 allowance*	Reimbursed up to $105

*** Not subject to annual deductible.**

Display for comparison purposes only. Please refer to the full benefit summaries available through the district portal. Should question arrise, summary/contract will be source of truth.