PacificSource HEALTH PLANS

West Linn Wilsonville School District – Admin/Confidential

Medical Benefit Summary
Navigator 200_10 S3

Benefit Year: Calendar Year

Provider Network: Navigator

Deductible Per Benefit Year	In-network and Out-of-network
Individual/Family	$200/$400
Out-of-Pocket Limit Per Benefit Year	**In-network and Out-of-network**
Individual/Family	$1,600/$3,200

Note: 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%	No deductible, 40%
Preventive physicals	No deductible, 0%	No deductible, 40%
Well woman visits	No deductible, 0%	No deductible, 40%
Preventive mammograms	No deductible, 0%	No deductible, 40%
Immunizations	No deductible, 0%	No deductible, 40%
Preventive colonoscopy	No deductible, 0%	No deductible, 40%
Prostate cancer screening	No deductible, 0%	No deductible, 40%
Professional Services		
Office and home visits	After deductible, 10%	After deductible, 40%
Naturopath office visits	After deductible, 10%	After deductible, 40%
Specialist office and home visits	After deductible, 10%	After deductible, 40%
Telehealth visits	After deductible, 10%	After deductible, 40%

Service/Supply	In-network Member Pays	Out-of-network Member Pays
Office procedures and supplies	After deductible, 10%	After deductible, 40%
Surgery	After deductible, 10%	After deductible, 40%
Outpatient rehabilitation and habilitation services	After deductible, 10%	After deductible, 40%
Acupuncture (12 visits per benefit year)	No deductible, $15	After deductible, 40%
Chiropractic manipulation/Spinal manipulation (20 visits per benefit year)	No deductible, $15	After deductible, 40%
Massage therapy ($500 per benefit year)	No deductible, $25	After deductible, 40%
Hospital Services		
Inpatient room and board	After deductible, 10%	After deductible, 40%
Inpatient rehabilitation and habilitation services	After deductible, 10%	After deductible, 40%
Skilled nursing facility care	After deductible, 10%	After deductible, 40%
Outpatient Services		
Outpatient surgery/services	After deductible, 10%	After deductible, 40%
Diagnostic imaging – advanced	After deductible, 10%	After deductible, 40%
Diagnostic and therapeutic radiology/laboratory and dialysis – non-advanced	After deductible, 10%	After deductible, 40%
Urgent and Emergency Services		
Urgent care center visits	After deductible, 10%	After deductible, 10%
Emergency room visits – medical emergency	After deductible, 10%	After deductible, 10%
Emergency room visits – non-emergency	After deductible, 10%	After deductible, 10%
Ambulance, ground	After deductible, 30%	After deductible, 30%
Ambulance, air	After deductible, 30%	After deductible, 30%
Maternity Services**		

Service/Supply	In-network Member Pays	Out-of-network Member Pays
Physician/Provider services (global charge)	After deductible, 10%	After deductible, 40%
Hospital/Facility services	After deductible, 10%	After deductible, 40%
Mental Health and Substance Use Disorder Services		
Office visits	After deductible, 10%	After deductible, 40%
Inpatient care	After deductible, 10%	After deductible, 40%
Residential programs	After deductible, 10%	After deductible, 40%
Other Covered Services		
Allergy injections	After deductible, 10%	After deductible, 40%
Durable medical equipment	After deductible, 10%	After deductible, 40%
Home health services	After deductible, 10%	After deductible, 40%
Transplants	After deductible, 10%	After deductible, 40%
Temporomandibular joint	After deductible, 10%	After deductible, 40%

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

** 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.

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

PacificSource HEALTH PLANS

West Linn Wilsonville School District – Admin/Confidential

Benefit Year: Calendar Year

Formulary: Oregon Drug List (ODL)

This plan includes coverage for prescription drugs and certain other pharmaceuticals, subject to the information below. This plan complies with federal healthcare reform. To check which tier your prescription falls under, call our Customer Service team or visit PacificSource.com/find-a-drug.

Prescription Drug Out-of-Pocket Limit $1,000 per individual/ $2,000 per family

The amount you pay for covered prescriptions at in-network pharmacies applies toward your plan's in-network prescription drug out-of-pocket limit, the amount you pay for covered prescriptions at out-of-network pharmacies applies toward your plan's prescription drug out-of-network out-of-pocket limit. The copayment and/or coinsurance for prescription drugs obtained from an in-network pharmacy is waived during the remainder of a benefit year in which you have satisfied a Prescription Drug out-of-pocket limit. The limit applies to each member. Claims must be submitted by the in-network pharmacy electronically. The difference between brand name and generic drugs (depending on your MAC (Maximum Allowable Cost) penalties), and drugs obtained at an out-of-network pharmacy does not apply toward the limit.

PacificSource Expanded (Preventive) No-cost Drug List

Your prescription benefit includes certain outpatient drugs as a preventive benefit at no deductible, $0 copay. This includes specific drugs that are taken regularly to prevent a disease or to keep a specific disease or condition from progressing. You can get a list of covered preventive drugs by contacting our Customer Service team or visit PacificSource.com and select Find a Drug.

Affordable Care Act Standard Preventive No-cost Drug List

Your prescription benefit includes preventive care drugs at no cost to you and are not subject to a deductible or MAC penalties. This benefit includes some drugs required by the Affordable Care Act, including tobacco cessation drugs. These drugs are identified on the drug list as Tier 0.

Each time a covered prescription is dispensed, you are responsible for any amounts shown above, in addition to the following amounts:

Service/ Supply	Tier 1 Member Pays	Tier 2 Member Pays	Tier 3 Member Pays	Tier 4 Member Pays
In-network Retail Pharmacy				
Up to a 30 day supply:	No deductible, $5	No deductible, $10+	No deductible, $25+	No deductible, the lesser of $150 or 10%
31 - 60 day supply:	No deductible, $10	No deductible, $20+	No deductible, $50+	No deductible, the lesser of $300 or 10%
61 - 90 day supply:	No deductible, $15	No deductible, $30+	No deductible, $75+	No deductible, the lesser of $450 or 10%

In-network Mail Order Pharmacy				
Up to a 90 day supply:	No deductible, $10	No deductible, $20+	No deductible, $50+	No deductible, the lesser of $300 or 10%
Compound Drugs**				
Up to a 30 day supply:	No deductible, $25			
31 - 60 day supply:	No deductible, $50			
61 - 90 day supply:	No deductible, $75			
Out-of-network Pharmacy				
30 day maximum fill, no more than three fills allowed per year:	No deductible, 90%			

+Formulary prescription insulin will not be subject to a deductible and may not exceed $80 per 30 day supply.

**Compounded medications are subject to a prior authorization process. Compounds are generally covered only when all commercially available formulary products have been exhausted and all the ingredients in the compounded medications are on the applicable formulary.

Specialty Medications must be filled through an in-network specialty pharmacy and are limited to a 30 day supply.

MAC B - Unless the prescribing provider requires the use of a brand name drug, the prescription will automatically be filled with a generic drug when available and permissible by state law. If you receive a brand name drug when a generic is available, you will be responsible for the brand name drug's copayment and/or coinsurance plus the difference in cost between the brand name drug and its generic equivalent. If your prescribing provider requires the use of a brand name drug, the prescription will be filled with the brand name drug and you will be responsible for the brand name drug's copayment and/or coinsurance. The cost difference between the brand name and generic drug does not apply toward the medical out-of-pocket limit. Does not apply to preventive bowel prep kits covered under USPSTF guidelines.

If your provider prescribes a brand name contraceptive due to medical necessity it may be subject to prior authorization for coverage at no charge.

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

PacificSource HEALTH PLANS

Vision Benefit Summary
Vision Plus S3

West Linn Wilsonville School District – Admin/Confidential

Benefit Year: Calendar Year

The following shows the vision benefits available under this plan for all covered vision exams, lenses, and frames when performed or prescribed by a licensed ophthalmologist or licensed optometrist. Coverage for pediatric services will end on the last day of the month in which the member turns 19. Copayment and/or coinsurance for covered charges apply to the medical plan's out-of-pocket limit.

Service/Supply	In-network Member Pays	Out-of-network Member Pays
All Members		
Eye exam	No deductible, $10	No deductible, 0% up to $40 then 100%
Single vision lenses	No deductible, $10	No deductible, 0% up to $40 then 100%
Bifocal lenses	No deductible, $10	No deductible, 0% up to $60 then 100%
Trifocal lenses	No deductible, $10	No deductible, 0% up to $80 then 100%
Lenticular lenses	No deductible, $10	No deductible, 0% up to $80 then 100%
Progressive lenses	No deductible, $75	No deductible, 0% up to $60 then 100%
Frames	No deductible, 0% up to $150 then 100%	No deductible, 0% up to $45 then 100%
Contact Lenses (in lieu of glasses)		
Contact lenses	No deductible, 0% up to $120 then 100%	No deductible, 0% up to $105 then 100%

Benefit Limitations: members age 18 and younger

- One vision exam every 12 months.
- Vision hardware includes glasses (lenses and frames) and/or contacts (lenses and fitting) once every 12 months.

Benefit Limitations: members age 19 and older

- One vision exam every 12 months.
- Lenses: One pair every 12 months.
- Frames: Once every 12 months.
- Contact lenses: Once every 12 months.

- Elective contact lenses are in lieu of frames and lenses.

Exclusions

- Charges for services or supplies covered in whole or in part under any medical or vision benefits provided by an employer.
- Duplication of spare eyeglasses or any lenses or frames for members age 18 and younger.
- Expenses covered under any workers' compensation law.
- Eye exams required as a condition of employment, required by a labor agreement or government body.
- Medical or surgical treatment of the eye.
- Nonprescription lenses.
- Plano contact lenses.
- Polycarbonate lenses for members age 19 and older.
- Replacement of lost, stolen, or broken lenses or frames.
- Services or supplies not listed as covered services.
- Services or supplies received before this plan's coverage begins or after it ends.
- Special procedures, such as orthoptics or vision training.
- Special supplies, such as sunglasses and subnormal vision aids.
- Visual analysis that does not include refraction.

Important information about your vision benefits

Your plan includes coverage for vision services. To make the most of those benefits, it's important to keep in mind the following:

In-network 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: Our provider contracts require in-network providers to bill us directly whenever you receive covered services and supplies. Providers will verify your vision benefits.

In-network 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 maximum benefit. If you are asked to pay the entire amount in advance, tell the provider you understand they have a contract with PacificSource and they should bill PacificSource directly.

Sales and Special Promotions (sales and promotions are not considered insurance): 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 in-network providers already discount their services through their contract with PacificSource, your plan's in-network benefits cannot be combined with any other discounts or coupons. You can use your plan's in-network benefits, or you can use your plan's out-of-network benefits to take advantage of a sale or coupon offer.

If you do take advantage of a special offer, the in-network 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 out-of-network benefits.