West Linn Wilsonville School District #3Jt

Licensed Medical Plan Options

Effective 10/1/2020

Plan Name	PacificSource Pathfinder 200_10 S3, $10-15-25 1000 OP Rx, Vision Plus, Alt Care (Previous HN PPO 100 Plan)		PacificSource Pathfinder 300_20 S3, $10-15-25 1000 OP Rx, Vision Plus, Alt Care (Previous HN PPO 200 Plan)		PacificSource Pathfinder Voyager 100+10_10 S4, $10-15-25 1000 OP Rx, Vision Plus, Alt Care (Previous HN POS 3 Tier Plan)			PacificSource Pathfinder 1600_30+Rx Non Embedded S3, Vision Plus, Alt Care (Previous HN HDHP)	
Plan Info	**In Network**	**Out of Network**	**In Network**	**Out of Network**	**In Network Tier 1**	**In Network Tier 2**	**Out of Network Tier 3**	**In Network**	**Out of Network**
Annual Deductible/Individual	$200		$300		$100		$200	$1,600	$3,200
Annual Deductible/Family	$400		$600		$200		$400	$3,200	$6,400
Annual Out-of-Pocket Maximum/Individual	$1,600		$1,200		$2,000		$6,000	$3,500	$10,500
Annual Out-of-Pocket Maximum/Family	$3,200		$2,400		$4,000		$12,000	$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*	40%*	Covered in Full*	Covered in Full*	30%*	Covered in Full*	50%*
Office Visit	10%	40%	20%	40%	$10 Copay*	30%	30%	30%	50%
Specialist Visit	10%	40%	20%	40%	$10 Copay*	30%	30%	30%	50%
Naturopaths	10%	40%	20%	40%	$10 Copay*	30%	30%	30%	50%
Diagnostic & Therapeutic Radiology/Lab	10%	40%	20%	40%	10%	30%	30%	30%	50%
Advanced Diagnostic Imaging	10%	40%	20%	40%	10%	30%	30%	30%	50%
Urgent Care	10%	10%	20%	20%	$35 Copay*	$35 Copay*	$35 Copay*	30%	30%
Hospital Services									
Inpatient Hospitalization	10%	40%	20%	40%	$100 Copay per day*	30%	30%	30%	50%
Outpatient Surgery	10%	40%	15% Ambulatory Surgery Center 20% Hospital-Based	40%	$100 Copay per visit*	25% Ambulatory Surgery Center 30% Hospital-Based		25% Ambulatory Surgery Center 30% Hospital-Based	50%
Emergency Room	10%	10%	20%	20%	$150 copay*	$150 copay*	$150 copay*	30%	30%
Ambulance (ground/air)	30%	30%	30%	30%	30%	30%	30%	30%	30%
Alternative Care	**$1,000 Combined Annual Max Chiro/Acup/Massage**		**$1,000 Combined Annual Max Chiro/Acup/Massage**		**$1,000 Combined Annual Max Chiro/Acup/Massage**			**$1,000 Combined Annual Max Chiro/Acup/Massage**	
Chiropractic Manipulation	$15 Copay / visit*	40%	$15 Copay / visit*	40%	$15 Copay / visit*	$15 Copay / visit*	30%	30%	50%
Acupuncture	$15 Copay / visit*	40%	$15 Copay / visit*	40%	$15 Copay / visit*	$15 Copay / visit*	30%	30%	50%
Massage Therapy	$25 Copay / visit*	40%	$25 Copay / visit*	40%	$25 Copay / visit*	$25 Copay / visit*	30%	30%	50%
Prescription Drug Benefits	**$1,000 Out of Pocket Maximum ($2,000 Family)**		**$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			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	Up to a 90 day supply	Up to a 30 day supply
Tier 1 (Per 30 day supply)	$10 Copay*	90%*	$10 Copay*	90%*	$10 Copay*		90%*	20%	90%
Tier 2 (Per 30 day supply)	$15 Copay*	90%*	$15 Copay*	90%*	$15 Copay*		90%*	20%	90%
Tier 3 (Per 30 day supply)	$25 Copay*	90%*	$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%*	Lesser of $150 or 10%*		90%*	20%	90%
Compound Drugs - (30 day max)	$25 Copay*	90%*	$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			Up to a 90 day supply	
Tier 1 (Per 90 day supply)	$20 Copay*		$20 Copay*		$20 Copay*			20%	
Tier 2 (Per 90 day supply)	$30 Copay*	NA	$30 Copay*	NA	$30 Copay*		NA	20%	NA
Tier 3 (Per 90 day supply)	$50 Copay*		$50 Copay*		$50 Copay*			20%	
Tier 4 (Per 90 day supply)	Lesser of $300 or 10%*		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)	$25 Copay* ($75 Copay for Standard Progressives)						Reimbursement varies $40 - $80*		
Frames (Every 24 months)	$100 allowance*						Reimbursed up to $45*		
Contact Lenses in Lieu of Glasses (Every 12 months)	$90 allowance*						Reimbursed up to $90*		

*** 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.