West Linn Wilsonville School District – Admin/Confidential

Provider Network: **Pathfinder**

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

Note: Your actual costs for services provided by an out-of-network provider may exceed this policy's out-of-pocket limit for out-of-network services. In addition, out-of-network providers can bill you for the difference between the amount charged by the provider and the amount allowed by the insurance company, and this amount is not counted toward the out-of-network out-of-pocket limit. Please see allowable fee in the Definitions section of your member 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		
Primary care provider (PCP) 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%
Telemedicine visits	After deductible, 10%	After deductible, 40%
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%

Service/Supply	In-network Member Pays	Out-of-network Member Pays
Chiropractic manipulations, acupuncture, and massage therapy ($1,000 per benefit year.	Chiropractic/acupuncture: No deductible, $15 Massage therapy: 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%
Advanced diagnostic imaging	After deductible, 10%	After deductible, 40%
Diagnostic and therapeutic radiology/lab and dialysis	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**		
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 member 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, co-payment, or co-insurance.

+ Out-of-network air ambulance coverage is covered at 200 percent of the Medicare allowance. You may be held responsible for the amount billed in excess. Please see your member handbook for additional information or contact our Customer Service team with questions.

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. Deductible expense is applied to the out-of-pocket limit.

In-network provider expense and out-of-network provider 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 medical expenses during the plan 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 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 member 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 provider expense and out-of-network provider expense apply together toward your out-of-pocket limits.

Primary care physician or primary care provider (PCP)

You are highly encouraged to select a PCP from the plan's provider directory. The PCP will coordinate healthcare resources to best meet your needs. Referrals are not required.

Payments to providers

Payment to providers is based on the prevailing or contracted PacificSource fee allowance for covered services. In-network providers accept the fee allowance as payment in full. Out-of-network providers are allowed to balance bill any remaining balance that your plan did not cover. Services of out-of-network providers could result in out-of-pocket expense in addition to the percentage indicated.

Preauthorization

Coverage of certain medical services and surgical procedures requires a benefit determination by PacificSource before the services are performed. This process is called preauthorization. Preauthorization is necessary to determine if certain services and supplies are covered under this plan, and if you meet the plan's eligibility requirements. Preauthorization does not change your out-of-pocket expense for in-network and out-of-network providers. You'll find the most current preauthorization list on our website, PacificSource.com/member/preauthorization.aspx.

PacificSource HEALTH PLANS

Prescription Drug Benefit Summary
OR 5-10-25 1000OP S2 ODL

West Linn Wilsonville School District

Formulary: Oregon Drug List (ODL)

This PacificSource health 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/drug-list.

The amount you pay for covered prescriptions at in-network and out-of-network pharmacies does not apply toward your plan's in-network medical out-of-pocket limit, which is shown on the Medical Benefit Summary.

Prescription Drug Out-of-Pocket Limit

$1,000 per person/$2,000 per family

The co-payment and/or co-insurance for prescription drugs obtained from an in-network pharmacy is waived at in-network pharmacies during the remainder of a calendar 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, and drugs obtained at an out-of-network pharmacy does not apply toward the limit.

PacificSource Expanded No Cost Drug List

Your prescription benefit includes certain outpatient drugs as a preventive benefit at no deductible, $0. This includes specific drugs that are taken regularly to prevent a disease or to keep a specific disease or condition from progressing. Preventive drugs are taken to help avoid many illnesses and conditions. You can get a list of covered preventive drugs by contacting our Customer Service team or visit PacificSource.com/drug-list to view the PacificSource Expanded No Cost Drug List.

Each time a covered prescription is dispensed, you are responsible for the amounts below:

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%

Service/ Supply	Tier 1 Member Pays	Tier 2 Member Pays	Tier 3 Member Pays	Tier 4 Member Pays
Compound Drugs**				
Up to a 30 day supply:	No deductible, $25			
Out-of-network Pharmacy				
30 day max fill, no more than three fills allowed per year:	No deductible, 90%			

^Remember to show your PacificSource member ID card each time you fill a prescription at a retail pharmacy. If your ID card is not used, your benefits cannot be applied and may result in higher out-of-pocket cost.

**Compounded medications are subject to a preauthorization 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 co-payment and/or co-insurance 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 co-payment and/or co-insurance. The cost difference between the brand name and generic drug does not apply toward the medical or prescription drug plan's out-of-pocket limit. Does not apply to preventive bowel prep kit medications covered under USPSTF guidelines.

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

See your member 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

The following shows the vision benefits available under this plan for enrolled members 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 enrolled member turns 19. Co-payment and/or co-insurance for covered charges apply to the medical plan's out-of-pocket limit.

If charges for a service or supply are less than the amount allowed, the benefit will be equal to the actual charge. If charges for a service or supply are greater than the amount allowed, the expense above the allowed amount is the member's responsibility and will not apply toward the member's medical plan deductible or out-of-pocket limit.

Service/Supply	In-network Member Pays	Out-of-network Member Pays
All Enrolled 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	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: enrolled members age 18 and younger

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

Benefit Limitations: enrolled 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 enrolled members age 19 and older.
- Replacement of lost, stolen, or broken lenses or frames.
- Services or supplies not listed as covered expenses.
- 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 PacificSource health 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: Please remember to show your current PacificSource member ID card whenever you use your plan's benefits. 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 co-payments and amounts over your plan's allowances. 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 provider benefits cannot be combined with any other discounts or coupons. You can use your plan's in-network provider benefits, or you can use your plan's out-of-network provider 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 provider benefits.