WHA INSURANCE

Fern Ridge School District

Plan Comparison - PacificSource

	PacificSource							
	$1000 Deductible		$1500 HSA		$5000 Deductible		$1000 Deductible	
Network	SmartChoice		SmartChoice		SmartChoice		PSN - Out of State	
Individual Deductible per Calendar Year	$1,000		$1,500		$5,000		$1,000	
Maximum Family Ded. Per Cal. Yr	$2,000		$3,000		$10,000		$2,000	
Out of Pocket Maximum - Individual	$3,500		$3,000		$5,600		$3,500	
Out of Pocket Maximum - Family	$7,000		$6,000		$11,200		$7,000	
Preventative Services								
Well-Baby care	Covered in Full		Covered in Full		Covered in Full		Covered in Full	
Immunizations all ages	Covered in Full		Covered in Full		Covered in Full		Covered in Full	
Routine physical Exams	Covered in Full		Covered in Full		Covered in Full		Covered in Full	
Routine, preventive colonoscopy	Covered in Full		Covered in Full		Covered in Full		Covered in Full	
Professional Services								
Office Visits including mental health/chemical dependency	$25 Copay *		20%		$35 Copay *		$25 Copay *	
Specialist Visits	$25 Copay *		20%		$35 Copay *		$25 Copay *	
Urgent Care Office Visits	$25 Copay *		20%		$35 Copay *		$25 Copay *	
Diagnostic Lab and X-ray	20% *		20%		20%		20% *	
Advanced Imaging	20%		20%		20%		20%	
Surgery	20%		20%		20%		20%	
Hospital Services								
Hospital Stay including mental health/chemical dependency	20%		20%		20%		20%	
Maternity Hospital	20%		20%		20%		20%	
Outpatient day surgery	20%		20%		20%		20%	
Emergency room visits	20% after $150 Copay *		20%		20%		20% after $150 Copay *	
Other Services								
Ambulance (ground)	20%		20%		20%		20%	
Ambulance (air)	50%		20%		50%		50%	
Outpatient durable medical equipment	20%		20%		20%		20%	
Rehabilitation	20%		20%		20%		20%	
Allergy Injections	$5 Copay *		20%		$5 Copay *		$5 Copay *	
Alternative Care								
Chiropractic, Acup. and Naturo. OV	$25 Copay *		20%		$35 Copay *		$25 Copay *	
Massage Therapy Office Visits	$25 Copay *		20%		$35 Copay *		$25 Copay *	
Annual Maximum	$1000 annual max		$1000 annual max		$1000 annual max		$1000 annual max	
Prescription Drug Benefit	**30 Day**	**90 Day**	**30 Day**	**90 Day**	**30 Day**	**90 Day**	**30 Day**	**90 Day**
Tier 1	$15 Copay *	$30 Copay *	20%	20%	$15 Copay *	$30 Copay *	$15 Copay *	$30 Copay *
Tier 2	$30 Copay *	$60 Copay *	20%	20%	$30 Copay *	$60 Copay *	$30 Copay *	$60 Copay *
Tier 3	$50 Copay *	$100 Copay *	20%	20%	$50 Copay *	$100 Copay *	$50 Copay *	$100 Copay *
Individual Out of Pocket Maximum	Medical OOP Max		Medical OOP Max		Medical OOP Max		Medical OOP Max	
Family Out of Pocket Maximum	Medical OOP Max		Medical OOP Max		Medical OOP Max		Medical OOP Max	
Vision								
Benefit Availability	Per calendar year		Per calendar year		Per calendar year		Per calendar year	
Exam	$10 Copay *		$10 Copay *		$10 Copay *		$10 Copay *	
Lens Benefits	Up to $400 Allowance		Up to $400 Allowance		Up to $400 Allowance		Up to $400 Allowance	
Frame Benefit								
Contact Lens Benefit *(in place of glasses)*								

**** - Deductible Waived***

For illustration purposes only. If a conflict arises, carrier information takes precedence.