

Northwest Wood Products Trust (NWPT)

Provider Network: **Voyager**

Deductible Per Calendar Year	In-network and Out-of-network	
<b>Individual/Family</b>	\$1,000/\$3,000	
Out-of-Pocket Limit Per Calendar Year	In-network	Out-of-network
<b>Individual/Family</b>	\$6,850/\$13,700	\$7,000/Not applicable
<p><b>Note:</b> Your actual costs for services provided by an out-of-network provider may exceed this plan'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.</p>		

**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
<b>Preventive Care</b>		
<b>Well baby/Well child care</b>	No deductible, 0%	No deductible, 20%
<b>Preventive physicals</b>	No deductible, 0%	No deductible, 20%
<b>Well woman visits</b>	No deductible, 0%	No deductible, 20%
<b>Preventive mammograms</b>	No deductible, 0%	No deductible, 20%
<b>Immunizations</b>	No deductible, 0%	No deductible, 20%
<b>Preventive colonoscopy</b>	No deductible, 0%	After deductible, 40%
<b>Prostate cancer screening</b>	No deductible, 0%	No deductible, 20%
<b>Professional Services</b>		
<b>Office and home visits</b>	No deductible, \$20	No deductible, \$20 plus 20%
<b>Naturopath office visits</b>	No deductible, \$20	No deductible, \$20 plus 20%
<b>Specialist office and home visits</b>	No deductible, \$30	No deductible, \$20 plus 20%
<b>Telemedicine visits</b>	No deductible, \$10	No deductible, \$10 plus 20%
<b>Office procedures and supplies</b>	After deductible, 20%	After deductible, 40%
<b>Surgery</b>	After deductible, 20%	After deductible, 40%
<b>Outpatient rehabilitation and habilitation services</b>	No deductible, \$20	After deductible, 30%
<b>Hospital Services</b>		
<b>Inpatient room and board</b>	After deductible, 20%	After deductible, 40%
<b>Inpatient rehabilitation and habilitation services</b>	After deductible, 20%	After deductible, 40%

<b>Service/Supply</b>	<b>In-network Member Pays</b>	<b>Out-of-network Member Pays</b>
<b>Skilled nursing facility care</b>	After deductible, 20%	After deductible, 40%
<b>Outpatient Services</b>		
<b>Outpatient surgery/services</b>	After deductible, 20%	After deductible, 40%
<b>Advanced diagnostic imaging</b>	After deductible, 20%	After deductible, 40%
<b>Diagnostic and therapeutic radiology / lab and dialysis</b>	No deductible, 20%	After deductible, 40%
<b>Urgent and Emergency Services</b>		
<b>Urgent care center visits</b>	No deductible, \$20	No deductible, \$20 plus 20%
<b>Emergency room visits – medical emergency</b>	No deductible, \$250 plus 20%^	No deductible, \$250 plus 20%^
<b>Emergency room visits – non-emergency</b>	No deductible, \$250 plus 20%^	No deductible, \$250 plus 40%^
<b>Ambulance, ground</b>	After deductible, 20%	After deductible, 20%
<b>Ambulance, air</b>	After deductible, 50%	After deductible, 50%+
<b>Maternity Services**</b>		
<b>Physician/Provider services (global charge)</b>	After deductible, 20%	After deductible, 40%
<b>Hospital/Facility services</b>	After deductible, 20%	After deductible, 40%
<b>Mental Health and Substance Use Disorder Services</b>		
<b>Office visits</b>	No deductible, \$20	No deductible, \$20 plus 20%
<b>Inpatient care</b>	After deductible, 20%	After deductible, 40%
<b>Residential programs</b>	After deductible, 20%	After deductible, 40%
<b>Other Covered Services</b>		
<b>Allergy injections</b>	No deductible, \$5	No deductible, \$5 plus 20%
<b>Durable medical equipment</b>	After deductible, 20%	After deductible, 50%
<b>Home health services</b>	After deductible, 20%	After deductible, 50%
<b>Transplants</b>	After deductible, 0%	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.**

^ Co-pay applies to ER physician and facility charges only. Co-pay waived if admitted into hospital.

\*\* 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 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.

Note that there is a separate category for in-network and out-of-network when it comes to meeting your out-of-pocket limit. Only in-network expense applies to the in-network out-of-pocket limit. Only out-of-network expense applies to the out-of-network out-of-pocket limit.

## 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](https://www.pacificsource.com/member/preauthorization.aspx).