PacificSource HEALTH PLANS

Northwest Wood Products Trust (NWPT)

Medical Benefit Summary
Voyager 1000+20-30_20 S2

Benefit Year: Calendar Year

Provider Network: Voyager

Deductible Per Benefit Year	In-network and Out-of-network	
Individual/Family	$1,000/$3,000	
Out-of-Pocket Limit Per Benefit Year	**In-network**	**Out-of-network**
Individual/Family	$6,850/$13,700	$7,000/Not applicable

Note: In-network out-of-pocket limit accumulates separately from the out-of-network out-of-pocket limit. Even though you may have the same benefit for in-network and out-of-network, 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 situations 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, 20%
Preventive physicals	No deductible, 0%	No deductible, 20%
Well woman visits	No deductible, 0%	No deductible, 20%
Preventive mammograms	No deductible, 0%	No deductible, 20%
Immunizations	No deductible, 0%	No deductible, 20%
Preventive colonoscopy	No deductible, 0%	After deductible, 40%
Prostate cancer screening	No deductible, 0%	No deductible, 20%
Professional Services		
Office and home visits	First three visits no deductible, $5. Subsequent visits, no deductible, $20*	No deductible, $20 plus 20%

Service/Supply	In-network Member Pays	Out-of-network Member Pays
Naturopath office visits	No deductible, $20	No deductible, $20 plus 20%
Specialist office and home visits	No deductible, $30	No deductible, $20 plus 20%
Telehealth visits	First three visits no deductible, $5. Subsequent visits, no deductible, $20*	No deductible, $20 plus 20%
Office procedures and supplies	After deductible, 20%	After deductible, 40%
Surgery	After deductible, 20%	After deductible, 40%
Outpatient rehabilitation and habilitation services	No deductible, $20	After deductible, 30%
Hospital Services		
Inpatient room and board	After deductible, 20%	After deductible, 40%
Inpatient rehabilitation and habilitation services	After deductible, 20%	After deductible, 40%
Skilled nursing facility care	After deductible, 20%	After deductible, 40%
Outpatient Services		
Outpatient surgery/services	After deductible, 20%	After deductible, 40%
Diagnostic imaging – advanced	After deductible, 20%	After deductible, 40%
Diagnostic and therapeutic radiology/laboratory and dialysis – non-advanced	No deductible, 20%	After deductible, 40%
Urgent and Emergency Services		
Urgent care center visits	No deductible, $20	No deductible, $20 plus 20%
Emergency room visits – medical emergency	No deductible, $250 plus 20%^	No deductible, $250 plus 20%^
Emergency room visits – non-emergency	No deductible, $250 plus 20%^	No deductible, $250 plus 40%^
Ambulance, ground	After deductible, 20%	After deductible, 20%
Ambulance, air	After deductible, 50%	After deductible, 50%
Maternity Services**		
Physician/Provider services (global charge)	After deductible, 20%	After deductible, 40%
Hospital/Facility services	After deductible, 20%	After deductible, 40%

Service/Supply	In-network Member Pays	Out-of-network Member Pays
Mental Health and Substance Use Disorder Services		
Office visits	First three visits no deductible, $5. Subsequent visits, no deductible, $20*	No deductible, $20 plus 20%
Inpatient care	After deductible, 20%	After deductible, 40%
Residential programs	After deductible, 20%	After deductible, 40%
Other Covered Services		
Allergy injections	No deductible, $5	No deductible, $5 plus 20%
Durable medical equipment	After deductible, 20%	After deductible, 50%
Home health services	After deductible, 20%	After deductible, 50%
Transplants	After deductible, 0%	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.

^ Copay applies to ER physician and facility charges only. Copay waived if admitted into hospital.

*First three visits per benefit year combined for Professional Services – Office and home visits, Telehealth visits, and Mental Health and Substance Use Disorder Services – Office visits.

** 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.

Note that there is a separate category for in-network and out-of-network when it comes to meeting 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

Northwest Wood Products Trust (NWPT)

Prescription Drug Benefit Summary
OR 0-10-40-75 S4 ODL

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.

The amount you pay for covered prescriptions at in-network pharmacies applies toward your plan's in-network medical out-of-pocket limit, the amount you pay for covered prescriptions at out-of-network pharmacies applies toward your plan's out-of-network out-of-pocket limit which is shown on the Medical Benefit Summary. The copayment and/or coinsurance for prescription drugs obtained from an in-network or out-of-network pharmacy are waived during the remainder of the benefit year in which you have satisfied the medical out-of-pocket limit.

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 when filled at an in-network pharmacy. 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	Incentive Drugs:	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, $0	No deductible, $10*	No deductible, $40*	No deductible, $75*	No deductible, 30%
31 - 60 day supply:	No deductible, $0	No deductible, $20	No deductible, $80	No deductible, $150	No deductible, 30%
61 - 90 day supply:	No deductible, $0	No deductible, $30	No deductible, $120	No deductible, $225	No deductible, 30%
In-network Mail Order Pharmacy					
Up to a 45 day supply:	No deductible, $0	No deductible, $10*	No deductible, $40*	No deductible, $75*	No deductible, 30%
46 - 90 day supply:	No deductible, $0	No deductible, $10	No deductible, $80	No deductible, $150	No deductible, 30%

Service/ Supply	Incentive Drugs:	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, $75			
31 - 60 day supply:		No deductible, $150			
61 - 90 day supply:		No deductible, $225			
Out-of-network Pharmacy					
30 day maximum fill, no more than three fills allowed per year:		No deductible, the greater of 50% or retail copay			

*Prescription insulin is not subject to a deductible and is limited to $35 copay per 30 day supply when filled at an in-network pharmacy.

**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 exception review for coverage at no charge.

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