

Provider Network: **Voyager**

Deductible Per Calendar Year	In-network	Out-of-network
<b>Individual/Family</b>	\$5,500/\$11,000	\$7,500/\$15,000
Out-of-Pocket Limit Per Calendar Year	In-network	Out-of-Pocket Limit
<b>Individual/Family</b>	\$7,500/\$15,000	\$11,250/\$22,500

Note: In-network deductible and out-of-pocket limit accumulate separately from the out-of-network deductible and 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 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.

**Accident Benefit**

The first \$500 of covered expenses within 90 days of an accident is covered up to the maximum benefit available and not subject to the deductible. The date of injury must occur after the member is enrolled in this plan. If date of injury occurred prior to being enrolled on this plan, this benefit will not apply. The balance is covered as shown below.

**The member is responsible for any amounts shown above, in addition to the following amounts:**

<b>Service/Supply</b>	<b>In-network Member Pays</b>	<b>Out-of-network Member Pays</b>
<b>Preventive Care</b>		
<b>Well baby/Well child care</b>	No deductible, 0%	After deductible, 50%
<b>Preventive physicals</b>	No deductible, 0%	After deductible, 50%
<b>Well woman visits</b>	No deductible, 0%	After deductible, 50%
<b>Preventive mammograms</b>	No deductible, 0%	After deductible, 50%
<b>Immunizations</b>	No deductible, 0%	After deductible, 50%
<b>Preventive colonoscopy</b>	No deductible, 0%	After deductible, 50%
<b>Prostate cancer screening</b>	No deductible, 0%	After deductible, 50%
<b>Professional Services</b>		
<b>Office and home visits</b>	No deductible, \$30	After deductible, 50%
<b>Naturopath office visits</b>	No deductible, \$30	After deductible, 50%
<b>Specialist office and home visits</b>	No deductible, \$60	After deductible, 50%

<b>Service/Supply</b>	<b>In-network Member Pays</b>	<b>Out-of-network Member Pays</b>
<b>Telemedicine visits</b>	No deductible, \$10	After deductible, 50%
<b>Newborn nurse home visits</b>	No deductible, 0%	After deductible, 50%
<b>Office procedures and supplies</b>	After deductible, 30%	After deductible, 50%
<b>Surgery</b>	After deductible, 30%	After deductible, 50%
<b>Outpatient rehabilitation services</b>	After deductible, 30%	After deductible, 50%
<b>Chiropractic manipulation and Acupuncture (\$1,000 per year)</b>	No deductible, \$30	After deductible, 50%
<b>Hospital Services</b>		
<b>Inpatient room and board</b>	After deductible, 30%	After deductible, 50%
<b>Inpatient rehabilitation services</b>	After deductible, 30%	After deductible, 50%
<b>Skilled nursing facility care</b>	After deductible, 30%	After deductible, 50%
<b>Outpatient Services</b>		
<b>Outpatient surgery/services</b>	After deductible, 30%	After deductible, 50%
<b>Advanced diagnostic imaging</b>	After deductible, 30%	After deductible, 50%
<b>Diagnostic and therapeutic radiology/lab and dialysis</b>	After deductible, 30%	After deductible, 50%
<b>Urgent and Emergency Services</b>		
<b>Urgent care center visits</b>	No deductible, \$30	After deductible, 50%
<b>Emergency room visits – medical emergency</b>	After deductible, \$250 plus 30%^	After deductible, \$250 plus 30%^
<b>Emergency room visits – non-emergency</b>	After deductible, \$250 plus 30%^	After deductible, \$250 plus 50%^
<b>Ambulance, ground</b>	After deductible, 30%	After deductible, 30%
<b>Ambulance, air</b>	After deductible, 30%	After deductible, 30%+
<b>Maternity Services**</b>		
<b>Physician/Provider services (global charge)</b>	After deductible, 30%	After deductible, 50%
<b>Hospital/Facility services</b>	After deductible, 30%	After deductible, 50%
<b>Mental Health and Substance Use Disorder Services</b>		
<b>Office visits</b>	No deductible, \$30	After deductible, 50%
<b>Inpatient care</b>	After deductible, 30%	After deductible, 50%
<b>Residential programs</b>	After deductible, 30%	After deductible, 50%
<b>Other Covered Services</b>		

<b>Service/Supply</b>	<b>In-network Member Pays</b>	<b>Out-of-network Member Pays</b>
<b>Allergy injections</b>	After deductible, 30%	After deductible, 50%
<b>Durable medical equipment</b>	After deductible, 30%	After deductible, 50%
<b>Home health services</b>	After deductible, 30%	After deductible, 50%
<b>Transplants</b>	After deductible, 0%	After deductible, 50%

**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.

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

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







- 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.
- 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:** 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 maximum benefit. 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 benefits cannot be combined with any other discounts or coupons. You can use your plan's in-network benefits, or you can use your plan's out-of-network 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.