



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at PacificSource.com or by calling 1-800-688-5008.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Participating: \$6350 person/\$12700 family Non-participating : \$12000 person/\$24000 family Doesn't apply to: Participating provider: tier one and two preventive care, tier one and two alt/chiro, tier one and two 1st 3 office visits, tier one and two pediatric vision exam and hardware. Non-participating provider: 1st \$75 of pediatric vision hardware. Generic Rx drugs.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. \$6350 person tier one and two participating provider combined \$12700 family tier one and two participating provider combined \$24000 person non-participating provider \$48000 family non-participating provider	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Does this plan use a network of providers?	Yes. For a list of preferred providers , see PacificSource.com or call 1-800-688-5008.	If you use an in-network doctor or other health care provider , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred , or participating for providers in their network . See the chart starting on page 2 for how this plan pays different kinds of providers .
Do I need a referral to see a specialist?	No.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about excluded services .

Group #: Standard
Create Date: 8/18/13

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- **Co-payments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **co-insurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **participating providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a SmartHealth Tier One Participating Provider	Your cost if you use a SmartHealth Tier Two Participating Provider	Your cost if you use a Non-participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	First 3 combined visits \$50 co-pay/visit, then No charge	No charge	50% co-insurance	---none---
	Specialist visit	First 3 combined visits \$50 co-pay/visit, then No charge	No charge	50% co-insurance	---none---
	Other practitioner office visit	Alternative and Chiropractic Care: \$50 co-pay/visit	Alternative and Chiropractic Care: \$50 co-pay/visit	Alternative and Chiropractic Care: 50% co-insurance	Alternative and Chiropractic Care: limited to a combined fifteen visits/year. No coverage for drugs, homeopathic medicines or supplies, and maternity. No coverage for Massage Therapy.
	Preventive care/ screening/immunization	No charge	No charge	50% co-insurance Tobacco Cessation: 90% co-insurance	Limited to: Routine Physicals: 13 visits ages 0-36 months, annually ages 3 and older. Well Woman Visits: annually. Immunizations: CDC and USPSTF Preventive Care Grade A and B Recommended. Preventive

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PacificSource: SmartHealth Balance Bronze 6350

Coverage Period: 01/01/1900 – 12/31/1900

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual + Family | Plan Type: HMO

					Colonoscopy: Ages 50-75.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	No charge	50% co-insurance	---none---
	Imaging (CT/PET scans, MRIs)	No charge	No charge	50% co-insurance	Pre-authorization required.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at PacificSource.com.	Generic drugs	Retail: \$10 co-pay Mail: \$20 co-pay	Retail: \$10 co-pay Mail: \$20 co-pay	Not covered (except 5-day emergency supply)	Retail limited to 30-day supply. Mail limited to 90-day supply. Pre-authorization required for certain drugs.
	Preferred brand drugs	Retail: No charge Mail: No charge	Retail: No charge Mail: No charge	Not covered (except 5-day emergency supply)	See Generic drugs above.
	Non-preferred brand drugs	Retail: No charge Mail: No charge	Retail: No charge Mail: No charge	Not covered (except 5-day emergency supply)	See Generic drugs above.
	Specialty drugs	No charge	No charge	Not covered (except 5-day emergency supply)	Coverage available only through our specialty pharmacy services provider. Limited to 30-day supply. Pre-authorization required for certain drugs.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	No charge	50% co-insurance	Pre-authorization required.
	Physician/surgeon fees	No charge	No charge	50% co-insurance	Pre-authorization required.
If you need immediate medical attention	Emergency room services	No charge	No charge	50% co-insurance	Non-participating paid as participating if emergency medical condition.
	Emergency medical transportation	No charge	No charge	No charge	Limited to nearest facility able to treat condition. Air covered if ground medically or physically inappropriate. Non-participating air covered up to Medicare allowance.

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	Urgent care	First 3 combined visits \$50 co-pay/visit, then No charge	No charge	50% co-insurance	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	No charge	50% co-insurance	Limited to semi-private room unless intensive or coronary care units, medically necessary isolation, or hospital only has private rooms. Pre-authorization required for some inpatient services.
	Physician/surgeon fee	No charge	No charge	50% co-insurance	---none---
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	First 3 combined visits \$50 co-pay/visit, then No charge	No charge	50% co-insurance	---none---
	Mental/Behavioral health inpatient services	No charge	No charge	50% co-insurance	Pre-authorization required.
	Substance use disorder outpatient services	First 3 combined visits \$50 co-pay/visit, then No charge	No charge	50% co-insurance	---none---
	Substance use disorder inpatient services	No charge	No charge	50% co-insurance	Pre-authorization required.
If you are pregnant	Prenatal and postnatal care	No charge	No charge	50% co-insurance	---none---
	Delivery and all inpatient services	No charge	No charge	50% co-insurance	Practitioner delivery and hospital visits are covered under prenatal and postnatal care. Facility is covered the same as any other hospital services. Pre-authorization required.
If you need help recovering or have other special health needs	Home health care	No charge	No charge	50% co-insurance	No coverage for private duty nursing or custodial care. Pre-authorization required.
	Rehabilitation services	Inpatient: No charge Outpatient: No charge	Inpatient: No charge Outpatient: No charge	Inpatient: 50% co-insurance Outpatient: 50% co-insurance	Inpatient: Pre-authorization required. Outpatient: Limited to combined 20 visits/year. No coverage for recreation therapy.
	Habilitation services	Inpatient:	Inpatient:	Inpatient:	Inpatient: Pre-authorization required.

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		No charge Outpatient: No charge	No charge Outpatient: No charge	50% co-insurance Outpatient: 50% co-insurance	Outpatient: Limited to combined 20 visits/year. No coverage for recreation therapy.
	Skilled nursing care	No charge	No charge	50% co-insurance	Limited to 30 days/year. No coverage for custodial care. Pre-authorization required.
	Durable medical equipment	No charge	No charge	50% co-insurance	Limited to: \$5,000/year overall; one/lifetime age 19+ for power-assisted wheelchairs; one pair/year for glasses or contact lenses to correct a specific vision defect from a severe medical or surgical problem; one breast pump/pregnancy; and \$150/year for wig for chemotherapy or radiation therapy. Pre-authorization required if over \$800.
	Hospice service	No charge	No charge	50% co-insurance	Pre-authorization required. No coverage for private duty nursing.
If your child needs dental or eye care	Eye exam	\$50 co-pay/visit	\$50 co-pay/visit	50% co-insurance	One routine eye exam per year for children 18 or younger when provided by a licensed ophthalmologist or optometrist.
	Glasses	No charge	No charge	No charge for first \$75 per year, then 100% co-insurance	One pair of non-collection glasses (lenses and frames) per year for children 18 or younger or contact lenses with certain limitations. Preauthorization required for purchases over \$175. Additional coatings not covered.
	Dental check-up	Not covered	Not covered	Not covered	Not covered

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Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)		
• Bariatric Surgery • Cosmetic Surgery • Custodial Care • Dental Care (Adult) • Dental Check-up(Child)	• Hearing aids (Adult) • Hearing Aids (Child) • Infertility Treatment • Long-term Care • Massage Therapy	• Non-emergency care when traveling outside the U.S. • Outpatient Recreational Therapy • Private Duty Nursing • Routine eye care (Adult) • Routine foot care, other than with diabetes mellitus
Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
• Acupuncture	• Chiropractic Care	• Weight Loss Programs

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-688-5008. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact the PacificSource Customer Service Department at 1-800-688-5008. For group health coverage subject to ERISA, you can also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additional, a consumer assistance program can help you file your appeal. Contact the Idaho Department of Insurance Consumer Assistance Division at 1-208-334-4250 or toll-free at 1-800-721-3272 (in-state only).

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage". **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-688-5008.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

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About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

■ Amount owed to providers:	\$7,540
■ Plan pays	\$1,190
■ Patient pays	\$6,350

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$6,350
Co-pays	\$0
Co-insurance	\$0
Limits or exclusions	\$0
Total	\$6,350

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

■ Amount owed to providers:	\$5,400
■ Plan pays	\$160
■ Patient pays	\$5,240

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$5,000
Co-pays	\$200
Co-insurance	\$0
Limits or exclusions	\$40
Total	\$5,240

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: 1-800-688-5008.

American Indian and Native American Benefits: If you are a Native American enrolled on this plan and receive services directly from the Indian Health Service, Indian Tribe, Tribal Organizations, or Urban Indian Organization, or through referral under the contract health services, the services will not be subject to any Deductible, Copayments, or Coinsurance.

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Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, co-payments, and co-insurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

- ✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- ✗ **No.** Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as co-payments, deductibles, and co-insurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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