



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?	\$7500 person/\$15000 family Doesn't apply to preventive care except preventive colonoscopies from a non-participating provider, office visits, vision, and emergency room.	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?	Yes. \$5000 for Maternity Services	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
Is there an out-of-pocket limit on my expenses?	Yes. \$10000 person participating provider \$20000 person non-participating provider \$20000 family 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, maternity deductible, co-pays, pharmacy, balanced-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 .
Is there an overall annual limit on what the plan pays?	Yes. \$2000000	This plan will pay for covered services only up to this limit during each coverage period, even if your own need is greater. You're responsible for all expenses above this limit. The chart starting on page 2 describes <i>specific</i> coverage limits, such as limits on the number of office visits.
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 .

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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		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you visit a healthcare <u>provider's office or clinic</u>	Primary care visit to treat an injury or illness	\$25 co-pay	\$25 co-pay/visit plus 50% co-insurance	---none---
	Specialist visit	\$25 co-pay	\$25 co-pay/visit plus 50% co-insurance	---none---
	Other practitioner office visit			
	Chiropractic Care	\$25 co-pay	\$25 co-pay/visit plus 50% co-insurance	Chiropractic Manipulation limited to a combined \$1,000/year. No coverage for drugs, homeopathic medicines/supplies, and maternity.
	Preventive care/screening/immunization			
	Routine Physicals	No charge	50% co-insurance	Limited to: Routine Physicals: 13 visits ages 0-36 months, annually ages 3 and older. Well
	Well Baby/Child Visit	No charge	50% co-insurance	Woman Visits: annually. Tobacco Cessation:
	Well Woman Visit	No charge	50% co-insurance	2 quit attempts in lifetime. Immunizations:
If you have a test	Tobacco Cessation	No charge	Not covered	CDC and USPSTF Preventive Care Grade A and B Recommended.
	Immunizations	No charge	50% co-insurance	
	Preventive Colonoscopy	No charge	50% co-insurance	
	Diagnostic test (x-ray, blood work)			
	Imaging (CT/PET scans, MRIs)			
		30% co-insurance	50% co-insurance	---none---
		30% co-insurance	50% co-insurance	Pre-authorization required; no coverage if not pre-authorized.

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PacificSource: IDAHO BRIGHTIDEA PREFERRED 7500

Summary of Benefits and Coverage: What this plan Covers and What it Costs

Coverage Period:

Coverage for: Individual + Family

Plan Type: PPO

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
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: \$10 co-pay	Not covered (except 5-day emergency supply) Not covered (except 5-day emergency supply)	Retail and Mail limited to 30-day supply. Pre-authorization required for certain drugs. Co-pays, differential between generic and brand drugs, and non-participating pharmacy charges do not accumulate to the RX deductible.
	Preferred brand drugs	After \$1000 brand name deductible - Retail: 50% co-insurance After \$1000 brand name deductible - Mail: 50% co-insurance	Not covered (except 5-day emergency supply) Not covered (except 5-day emergency supply)	See Generic drugs above
	Non-preferred brand drugs	Not Covered	Not Covered	Not Covered
	Specialty drugs	Same as the retail pharmacy	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)	30% co-insurance	50% co-insurance	---none---
	Physician/surgeon fees	30% co-insurance	50% co-insurance	---none---
If you need immediate medical attention	Emergency room services	\$100 co-pay/visit plus 30% co-insurance	\$100 co-pay/visit plus 50% co-insurance	Co-pay waived if admitted. Non-participating paid as participating if emergency medical condition.
	Emergency medical transportation Ground Ambulance Air Ambulance	30% co-insurance 30% co-insurance	30% co-insurance 30% co-insurance	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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Plan Type: PPO

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
	Urgent care	\$25 co-pay	\$25 co-pay/visit plus 50% co-insurance	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	30% co-insurance	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 inpatient elective surgery.
	Physician/surgeon fee	30% co-insurance	50% co-insurance	---none---
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	30% co-insurance	50% co-insurance	Outpatient: Limited to combined 20 visits per calendar year.
	Mental/Behavioral health inpatient services	30% co-insurance	50% co-insurance	Inpatient: Limited to combined 8 visits per calendar year.
	Substance use disorder outpatient services	30% co-insurance	50% co-insurance	Outpatient: Limited to combined 20 visits per calendar year.
	Substance use disorder inpatient services	30% co-insurance	50% co-insurance	Inpatient: Limited to combined 8 visits per calendar year.
If you are pregnant	Prenatal and postnatal care	After \$5000 maternity deductible: 30% co-insurance	After \$5000 maternity deductible: 50% co-insurance	---none---
	Delivery and all inpatient services	After \$5000 maternity deductible: 30% co-insurance	After \$5000 maternity deductible: 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.
If you need help recovering or have other special health needs	Home health care	30% co-insurance	50% co-insurance	Limited to: \$5,000 per calendar year. No coverage for private duty nursing. Pre-authorization required.
	Rehabilitation services: Inpatient	30% co-insurance	50% co-insurance	Inpatient: Limited to 15 days per calendar year. Pre-authorization required.
	Outpatient	30% co-insurance	50% co-insurance	Outpatient: Limited to 15 visits per calendar year for each type of therapy. Pre-authorization required.

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Coverage Period:

Coverage for: Individual + Family

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Common Medical Event	Services You May Need		Your cost if you use a		Limitations & Exceptions
			Participating Provider	Non-Participating Provider	
	Habilitation services:	Inpatient	30% co-insurance	50% co-insurance	Inpatient: Limited to 15 days per calendar year. Pre-authorization required. Outpatient: Limited to 15 visits per calendar year for each type of therapy. Pre-authorization required. Limited to 30 days/year. No coverage for custodial care. Pre-authorization required. Limited to: \$7,500/year overall; one/lifetime age 19+ for power-assisted wheelchairs; \$200 for glasses or contact lenses to correct a specific vision defect from a severe medical or surgical problem; \$4,000 per 48 months for hearing aid age 0-18 (or age 0-25 if student); and no coverage for adult hearing aids. Preauthorization required if over \$800. Preauthorization required for inpatient hospice. No coverage for private duty nursing.
		Outpatient	30% co-insurance	50% co-insurance	
	Skilled nursing care		30% co-insurance	50% co-insurance	
	Durable medical equipment		30% co-insurance	50% co-insurance	
	Hospice service		30% co-insurance	50% co-insurance	
If your child needs dental or eye care	Eye Exam		\$25 co-pay/visit	\$25 co-pay/visit plus 50% co-insurance	Once/year Single vision lenses and frames limited to \$100 every year. Additional coatings not covered Not Covered
	Glasses		No charge	No charge	
	Dental Check-up		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.)

- | | | |
|---|--|--|
| <ul style="list-style-type: none">NaturopathMassage TherapyDental Check-up(Child)Bariatric SurgeryAcupunctureCosmetic Surgery | <ul style="list-style-type: none">Dental Care (Adult)Infertility TreatmentHearing Aids (Adult)Long Term CareNon-emergency care when traveling outside the US | <ul style="list-style-type: none">Private Duty NursingRoutine foot care, other than with diabetes mellitusCustodial CareRecreational TherapyHearing Aids (Child) |
|---|--|--|

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.)

- | | | |
|--|--|--|
| <ul style="list-style-type: none">Glasses (Child)Vision Exam (Child) | <ul style="list-style-type: none">Chiropractic CareRoutine eye care (Adult) | <ul style="list-style-type: none">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 1-888-977-9299. 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.ccio.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 1-888-977-9299. 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. Additionally, 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).

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:	\$7540
■ Plan pays	\$720
■ Patient pays	\$6820

Sample care costs:

Hospital charges (mother)	\$2700
Routine obstetric care	\$2100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7540

Patient pays:

Deductibles	\$5000
Co-pays	\$20
Co-insurance	\$1600
Limits or exclusions	\$200
Total	\$6820

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

■ Amount owed to providers:	\$5400
■ Plan pays:	\$3360
■ Patient pays:	\$2040

Sample care costs:

Prescriptions	\$2900
Medical Equipment and Supplies	\$1300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5400

Patient pays:

Deductibles	\$1400
Co-pays	\$600
Co-insurance	\$0
Limits or exclusions	\$40
Total	\$2040

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.

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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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