



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?	\$3000 person/\$6000 family Doesn't apply to preventive care except preventive colonoscopies from a non-participating provider.	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. \$5800 person participating provider \$11600 family participating provider \$11600 person 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, benefits paid in full, charges for services on non-participating providers in excess of the allowable fee, 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	20% co-insurance	50% co-insurance	—none—
	Specialist visit	20% co-insurance	50% co-insurance	—none—
	Other practitioner office visit			
	Chiropractic Care	20% co-insurance	50% co-insurance	Chiropractic Manipulation limited to \$1000/year.
	Preventive care/screening/immunization			Limited to: Routine Physicals: 13 visits ages 0-36 months, annually ages 3 and older. Well
	Routine Physicals	No charge	50% co-insurance	Woman Visits: annually. Tobacco Cessation:
	Well Baby/Child Visit	No charge	50% co-insurance	2 quit attempts in lifetime. Immunizations:
	Well Woman Visit	No charge	50% co-insurance	CDC and USPSTF Preventive Care Grade A and B Recommended.
If you have a test	Tobacco Cessation	No charge	Not covered	
	Immunizations	No charge	50% co-insurance	
	Preventive Colonoscopy	No charge	50% co-insurance	
	Diagnostic test (x-ray, blood work)			—none—
		20% co-insurance	50% co-insurance	
	Imaging (CT/PET scans, MRIs)	20% co-insurance	50% co-insurance	Pre-authorization required; no coverage if not pre-authorized.

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PacificSource: IDAHO BRIGHTIDEA HSA 3000

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: 50% co-insurance Mail: 50% co-insurance	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 drug.
	Preferred brand drugs	Retail: 50% co-insurance 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)	20% co-insurance	50% co-insurance	---none---
	Physician/surgeon fees	20% co-insurance	50% co-insurance	---none---
If you need immediate medical attention	Emergency room services	\$100 co-pay/visit plus 20% 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	20% co-insurance 20% co-insurance	50% co-insurance 50% 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.
	Urgent care	20% co-insurance	50% co-insurance	---none---

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Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions	
		Participating Provider	Non-Participating Provider		
If you have a hospital stay	Facility fee (e.g., hospital room)	20% 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	20% co-insurance	50% co-insurance	---none---	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% co-insurance	50% co-insurance	Outpatient: Limited to combined 20 visits per calendar year.	
	Mental/Behavioral health inpatient services	20% co-insurance	50% co-insurance	Inpatient: Limited to combined 8 visits per calendar year. Pre-authorization required.	
	Substance use disorder outpatient services	20% co-insurance	50% co-insurance	Outpatient: Limited to combined 20 visits per calendar year.	
	Substance use disorder inpatient services	20% co-insurance	50% co-insurance	Inpatient: Limited to combined 8 visits per calendar year. Pre-authorization required.	
If you are pregnant	Prenatal and postnatal care	Not covered	Not covered	Not covered	
	Delivery and all inpatient services	Not covered	Not covered	Not covered	
If you need help recovering or have other special health needs	Home health care		20% co-insurance	50% co-insurance	Limited to: \$5,000 per calendar year. No coverage for private duty nursing. Pre-authorization required.
	Rehabilitation services:	Inpatient	20% co-insurance	50% co-insurance	Inpatient: Limited to 15 days per calendar year. Pre-authorization required.
		Outpatient	20% co-insurance	50% co-insurance	Outpatient: Limited to 15 visits per calendar year for each type of therapy. Pre-authorization required.
	Habilitation services:	Inpatient	20% co-insurance	50% co-insurance	Inpatient: Limited to 15 days per calendar year. Pre-authorization required.
		Outpatient	20% co-insurance	50% co-insurance	Outpatient: Limited to 15 visits per calendar year for each type of therapy. Pre-authorization required.
	Skilled nursing care		20% co-insurance	50% co-insurance	Limited to 30 days/year. No coverage for custodial care. Pre-authorization required.

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

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Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
	Durable medical equipment	20% co-insurance	50% co-insurance	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. Preauthorization required if over \$800. Preauthorization required for inpatient hospice. No coverage for private duty nursing.
	Hospice service	20% co-insurance	50% co-insurance	
If your child needs dental or eye care	Eye Exam	Not Covered	Not Covered	Not Covered
	Glasses	Not Covered	Not Covered	Not Covered
	Dental Check-up	Not Covered	Not Covered	Not Covered

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

Coverage Period:

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Plan Type: PPO

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](#).)

- | | | |
|---------------------------|--|--|
| • Naturopath | • Cosmetic Surgery | • Private Duty Nursing |
| • Massage Therapy | • Dental Care (Adult) | • Routine eye care (Adult) |
| • Glasses (Child) | • Infertility Treatment | • Routine foot care, other than with diabetes mellitus |
| • Dental Check-up(Child) | • Hearing Aids (Adult) | • Custodial Care |
| • Bariatric Surgery | • Long Term Care | • Recreational Therapy |
| • Vision Exam (Child) | • Non-emergency care when traveling outside the US | • Hearing Aids (Child) |
| • Acupuncture | | |

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.)

- | | |
|---------------------|------------------------|
| • 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 1-888-977-9299. 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.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 1-888-977-9299. 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	\$820
■ Patient pays	\$6720

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
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Patient pays:

Deductibles	\$20
Co-pays	\$0
Co-insurance	\$200
Limits or exclusions	\$6500

Total	\$6720
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Managing type 2 diabetes (routine maintenance of a well-controlled condition)

■ Amount owed to providers:	\$5400
■ Plan pays:	\$1460
■ Patient pays:	\$3940

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
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Patient pays:

Deductibles	\$3000
Co-pays	\$0
Co-insurance	\$900
Limits or exclusions	\$40

Total	\$3940
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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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