



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, go to <https://pacificsource.com/plan-details>. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary [HealthCare.gov/sbc-glossary](https://www.healthcare.gov/sbc-glossary) or call 1-800-688-5008 to request a copy.

| Important Questions   | Answers   | Why this Matters:  |
|---|---|--|
| <b>What is the overall <u>deductible</u>?</b>                             | \$3,300 individual/\$6,600 family   | Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .  |
| <b>Are there services covered before you meet your <u>deductible</u>?</b> | Yes. In-network: <u>preventive care</u> . In-network: preventive Rx drugs. Vision age 18 and younger - In-network: vision exam and hardware. Out-of-network: 1st \$40 vision exam and 1st \$75 vision hardware. | This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">Healthcare.gov/coverage/preventive-care-benefits/</a> .   |
| <b>Are there other <u>deductibles</u> for specific services?</b>          | No.   | You don't have to meet <u>deductibles</u> for specific services.   |
| <b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>       | \$5,300 individual/\$10,600 family  | The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.  |
| <b>What is not included in the <u>out-of-pocket limit</u>?</b>            | <u>Premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.   | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .   |
| <b>Will you pay less if you use a <u>network provider</u>?</b>            | Yes. See <a href="https://www.providerdirectory.pacificsource.com/?nPlan=Navigator">Providerdirectory.pacificsource.com/?nPlan=Navigator</a> or call 1-800-688-5008 for a list of network providers.            | This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services. |
| <b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b>          | No.   | You can see the <u>specialist</u> you choose without a <u>referral</u> .   |



All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

| What You Will Pay   |  |  |   |  |
|---|--|--|---|--|
| Common Medical Event  | Services You May Need                            | In-network<br>(You will pay the least)                         | Out-of-network<br>(You will pay the most) | Limitations, Exceptions, & Other Important Information   |
| <b>If you visit a health care provider's office or clinic</b>   | Primary care visit to treat an injury or illness | 20% <u>coinsurance</u>   | 40% <u>coinsurance</u>                    | None   |
|   | <u>Specialist</u> visit                          | 20% <u>coinsurance</u>   | 40% <u>coinsurance</u>                    | None   |
|   | <u>Preventive care/screening/immunization</u>    | No charge, <u>deductible</u> does not apply                    | 40% <u>coinsurance</u>                    | Preventive Physicals: 13 visits ages 0-36 months, annually ages 3 and older. Well Woman Visits: annually. You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.  |
| <b>If you have a test</b>   | <u>Diagnostic test</u> (x-ray, blood work)       | 20% <u>coinsurance</u>   | 40% <u>coinsurance</u>                    | None   |
|   | Imaging (CT/PET scans, MRIs)                     | 20% <u>coinsurance</u>   | 40% <u>coinsurance</u>                    | Prior authorization required.  |
| <b>If you need drugs to treat your illness or condition</b><br><br>More information about <u>prescription drug coverage</u> is available at <a href="https://pacificsource.com/drug-list">https://pacificsource.com/drug-list</a> | Tier one drugs                                   | Retail: 20% <u>coinsurance</u><br>Mail: 20% <u>coinsurance</u> | 20% <u>coinsurance</u>                    | Prescription benefit includes certain outpatient drugs as a preventive benefit at no charge when received in-network, <u>deductible</u> does not apply. <u>Cost share</u> amounts shown represent a 30 day supply at retail and a 90 day supply at mail order. Quantity for retail and mail order are limited to a 90 day supply. Quantity for <u>Specialty drug</u> is limited to 30 day supply. Prior authorization required for certain drugs. If a manufacturer coupon or rebate is used, the amount of the discount will not accumulate toward the deductible or the maximum out-of-pocket limit. |
|   | Tier two drugs                                   | Retail: 20% <u>coinsurance</u><br>Mail: 20% <u>coinsurance</u> | 20% <u>coinsurance</u>                    |  |
|   | Tier three drugs                                 | Retail: 20% <u>coinsurance</u><br>Mail: 20% <u>coinsurance</u> | 20% <u>coinsurance</u>                    |  |
|   | Specialty drugs                                  | 20% <u>coinsurance</u>   | 20% <u>coinsurance</u>                    |  |
| <b>If you have outpatient surgery</b>   | Facility fee (e.g., ambulatory surgery center)   | 20% <u>coinsurance</u>   | 40% <u>coinsurance</u>                    | None   |

| What You Will Pay  |   |  |  |  |
|--|---|--|--|--|
| Common Medical Event   | Services You May Need                     | In-network<br>(You will pay the least)   | Out-of-network<br>(You will pay the most)  | Limitations, Exceptions, & Other Important Information   |
|  | Physician/surgeon fees                    | 20% <u>co-insurance</u>  | 40% <u>co-insurance</u>  |  |
| <b>If you need immediate medical attention</b>                                   | <u>Emergency room care</u>                | Medical emergency: \$500 <u>co-pay/visit</u> plus 20% <u>co-insurance</u><br>Non-emergency: \$500 <u>co-pay/visit</u> plus 20% <u>co-insurance</u> | Medical emergency: \$500 <u>co-pay/visit</u> plus 20% <u>co-insurance</u><br>Non-emergency: \$500 <u>co-pay/visit</u> plus 40% <u>co-insurance</u> | <u>Co-pay</u> waived if admitted.  |
|  | <u>Emergency medical transportation</u>   | Ground: 20% <u>co-insurance</u><br>Air: 20% <u>co-insurance</u>  | Ground: 20% <u>co-insurance</u><br>Air: 20% <u>co-insurance</u>  | Limited to nearest facility able to treat condition. Air covered if ground medically or physically inappropriate. Out-of-network air based on 200 percent of Medicare allowance.   |
|  | <u>Urgent care</u>                        | 20% <u>co-insurance</u>  | 40% <u>co-insurance</u>  | None   |
| <b>If you have a hospital stay</b>   | Facility fee (e.g., hospital room)        | 20% <u>co-insurance</u>  | 40% <u>co-insurance</u>  | Limited to semi-private room unless intensive or coronary care units, <u>medically necessary</u> isolation, or hospital only has private rooms. Prior authorization required for some inpatient services.  |
|  | Physician/surgeon fees                    | 20% <u>co-insurance</u>  | 40% <u>co-insurance</u>  | None   |
| <b>If you need mental health, behavioral health, or substance abuse services</b> | Outpatient services                       | 20% <u>co-insurance</u>  | 40% <u>co-insurance</u>  | None   |
|  | Inpatient services                        | 20% <u>co-insurance</u>  | 40% <u>co-insurance</u>  | Prior authorization required for some inpatient services.  |
| <b>If you are pregnant</b>   | Office visits                             | 20% <u>co-insurance</u>  | 40% <u>co-insurance</u>  | <u>Cost sharing</u> does not apply for <u>preventive services</u> . Practitioner delivery and hospital visits are covered under prenatal and postnatal care. Facility is covered the same as any other hospital services. Elective abortions are excluded, except to save the life of the mother, or if the pregnancy is a result of rape or incest. |
|  | Childbirth/delivery professional services |  |  |  |
|  | Childbirth/delivery facility services     |  |  |  |

| What You Will Pay   |                                  |   |  |   |
|---|----------------------------------|---|--|---|
| Common Medical Event  | Services You May Need            | In-network<br>(You will pay the least)                                    | Out-of-network<br>(You will pay the most)  | Limitations, Exceptions, & Other<br>Important Information   |
| <b>If you need help recovering or have other special health needs</b> | <u>Home health care</u>          | 20% <u>co-insurance</u>   | 40% <u>co-insurance</u>  | Limited to 40 visits/year. No coverage for private duty nursing or custodial care.  |
|   | <u>Rehabilitation services</u>   | Inpatient: 20% <u>co-insurance</u><br>Outpatient: 20% <u>co-insurance</u> | Inpatient: 40% <u>co-insurance</u><br>Outpatient: 40% <u>co-insurance</u>  | Inpatient: Limited to 30 days/year. Prior authorization required.<br>Outpatient: Limited to 30 visits/year, additional visits may be prior authorized. No coverage for recreation therapy.  |
|   | <u>Habilitation services</u>     | Inpatient: 20% <u>co-insurance</u><br>Outpatient: 20% <u>co-insurance</u> | Inpatient: 40% <u>co-insurance</u><br>Outpatient: 40% <u>co-insurance</u>  | Inpatient: Limited to 30 days/year. Prior authorization required.<br>Outpatient: Limited to 30 visits/year, additional visits may be prior authorized. No coverage for recreation therapy.  |
|   | <u>Skilled nursing care</u>      | 20% <u>co-insurance</u>   | 40% <u>co-insurance</u>  | Limited to 60 days/year. No coverage for custodial care.  |
|   | <u>Durable medical equipment</u> | 20% <u>co-insurance</u>   | 40% <u>co-insurance</u>  | Limited to: one pair/year for glasses or contact lenses; one breast pump/pregnancy; \$150/year for wig for chemotherapy or radiation therapy. Prior authorization required if equipment is over \$2,500 and for power-assisted wheelchairs. |
|   | <u>Hospice services</u>          | 20% <u>co-insurance</u>   | 40% <u>co-insurance</u>  | No coverage for private duty nursing.   |
| <b>If your child needs dental or eye care</b>                         | Children's eye exam              | No charge, <u>deductible</u> does not apply                               | No charge, <u>deductible</u> does not apply, up to \$40 maximum then <u>Deductible</u> then 100% <u>co-insurance</u> | For age 18 or younger, one routine eye exam/year.   |
|   | Children's glasses               | No charge, <u>deductible</u> does not apply                               | No charge, <u>deductible</u> does not apply, up to \$75 then <u>Deductible</u> then 100% <u>co-insurance</u>         | For age 18 or younger, one pair of glasses (frames and lenses) and/or contacts (lenses and fitting) per year.   |
|   | Children's dental check-up       | Not covered   | Not covered  | Not covered   |

**Excluded Services & Other Covered Services:**

**Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)**

- Abortion (except in cases of rape, incest or to save the life of the mother)
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids (Adult)
- Hearing aids (Child)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care, other than with diabetes mellitus

**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)**

- Acupuncture
- Chiropractic care
- Routine eye care (Adult)
- Weight loss programs

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit [HealthCare.gov](http://HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: The PacificSource Customer Service team at 1-800-688-5008 or the Idaho Department of Insurance at 1-800-721-3272 or at [doi.idaho.gov](http://doi.idaho.gov). 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](http://www.dol.gov/ebsa/healthreform).

**Does this plan provide Minimum Essential Coverage? Yes.**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

**Does this plan meet Minimum Value Standards? Yes.**

If your plan doesn't meet the Minimum Value Standards you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

**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 section.*

## About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** \$3,300
- **Specialist** 20% co-insurance
- **Hospital (facility)** 20% co-insurance
- **Other** 20% co-insurance

**This EXAMPLE event includes services like:**

Specialist office visits (*prenatal care*)

Childbirth/Delivery Professional Services

Childbirth/Delivery Facility Services

Diagnostic tests (*ultrasounds and blood work*)

Specialist visit (*anesthesia*)

|  |                 |
|--|-----------------|
| <b>Total Example Cost</b>              | <b>\$12,700</b> |
| <b>In this example, Peg would pay:</b> |                 |
| <i>Cost Sharing</i>                    |                 |
| <u>Deductibles</u>                     | \$3300          |
| <u>Copayments</u>                      | \$0             |
| <u>Coinsurance</u>                     | \$1900          |
| <i>What isn't covered</i>              |                 |
| Limits or exclusions                   | \$60            |
| <b>The total Peg would pay is</b>      | <b>\$5,260</b>  |

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** \$3,300
- **Specialist** 20% co-insurance
- **Hospital (facility)** 20% co-insurance
- **Other** 20% co-insurance

**This EXAMPLE event includes services like:**

Primary care physician office visits (*including disease education*)

Diagnostic tests (*blood work*)

Prescription drugs

Durable medical equipment (*glucose meter*)

|  |                |
|--|----------------|
| <b>Total Example Cost</b>              | <b>\$5,600</b> |
| <b>In this example, Joe would pay:</b> |                |
| <i>Cost Sharing</i>                    |                |
| <u>Deductibles</u>                     | \$3300         |
| <u>Copayments</u>                      | \$0            |
| <u>Coinsurance</u>                     | \$400          |
| <i>What isn't covered</i>              |                |
| Limits or exclusions                   | \$20           |
| <b>The total Joe would pay is</b>      | <b>\$3,720</b> |

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- **The plan's overall deductible** \$3,300
- **Specialist** 20% co-insurance
- **Hospital (facility)** 20% co-insurance
- **Other** 20% co-insurance

**This EXAMPLE event includes services like:**

Emergency room care (*including medical supplies*)

Diagnostic test (*x-ray*)

Durable medical equipment (*crutches*)

Rehabilitation services (*physical therapy*)

|  |                |
|--|----------------|
| <b>Total Example Cost</b>              | <b>\$2,800</b> |
| <b>In this example, Mia would pay:</b> |                |
| <i>Cost Sharing</i>                    |                |
| <u>Deductibles</u>                     | \$2800         |
| <u>Copayments</u>                      | \$0            |
| <u>Coinsurance</u>                     | \$0            |
| <i>What isn't covered</i>              |                |
| Limits or exclusions                   | \$0            |
| <b>The total Mia would pay is</b>      | <b>\$2,800</b> |

The plan would be responsible for the other costs of these EXAMPLE covered services.