



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 <http://PacificSource.com/idaho/large-group-plan-details-2017Apr>. 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 <http://www.dol.gov/ebsa/healthreform> or call 1-800-688-5008 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	\$1,700 person/\$5,100 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> .
Are there services covered before you meet your deductible?	Yes. Participating: preventive care; office visits. Participating: Tier one Rx drugs.	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 preventive services without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	Yes. Pharmacy deductible \$250.	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the out-of-pocket limit for this plan?	Participating <u>provider</u> : \$4,200 person/\$8,400 family Non-participating <u>provider</u> : \$6,000 person/\$12,000 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.
What is not included in the out-of-pocket limit?	<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> .
Will you pay less if you use a network provider?	Yes. See http://providerdirectory.PacificSource.com/?nPlan=PSN or call 1-800-688-5008 for a list of <u>network providers</u> .	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</u> charge 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.
Do you need a referral to see a specialist?	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.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-participating Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$35 <u>co-pay</u> , <u>deductible</u> does not apply	<u>Deductible</u> then 50% <u>co-insurance</u>	None
	<u>Specialist</u> visit	\$50 <u>co-pay</u> , <u>deductible</u> does not apply	<u>Deductible</u> then 50% <u>co-insurance</u>	None
	<u>Preventive care/screening/immunization</u>	No charge, <u>deductible</u> does not apply	<u>Deductible</u> then 50% <u>co-insurance</u> Tobacco cessation: <u>Deductible</u> then 90% <u>co-insurance</u>	Routine Physicals: 1 hospital visit at birth, as recommended by child's pediatrician ages 0-7, annually ages 8 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.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	<u>Deductible</u> then 30% <u>co-insurance</u>	<u>Deductible</u> then 50% <u>co-insurance</u>	None
	Imaging (CT/PET scans, MRIs)	<u>Deductible</u> then 30% <u>co-insurance</u>	<u>Deductible</u> then 50% <u>co-insurance</u>	<u>Preauthorization</u> required.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at http://PacificSource.com/drug-list/ID/	Tier one drugs	Retail: \$15 <u>co-pay</u> , <u>deductible</u> does not apply Mail: \$15 <u>co-pay</u> , <u>deductible</u> does not apply	Same as retail	Retail limited to 90 day supply. Mail limited to 90 day supply. <u>Preauthorization</u> required for certain drugs.
	Tier two drugs	Retail: <u>Deductible</u> then \$40 <u>co-pay</u> Mail: <u>Deductible</u> then \$40 <u>co-pay</u>	Same as retail	
	Tier three drugs	Retail: <u>Deductible</u> then \$50 <u>co-pay</u> Mail: <u>Deductible</u> then \$50 <u>co-pay</u>	Same as retail	

Common Medical Event	Services You May Need	Participating Provider (You will pay the least)	Non-participating Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Tier four <u>specialty drugs</u>	Same as retail	Same as retail	Participating <u>provider</u> benefit available only through our specialty pharmacy services <u>provider</u> . Limited to 30 day supply. <u>Preauthorization</u> required for certain drugs.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	<u>Deductible</u> then 30% <u>co-insurance</u>	<u>Deductible</u> then 50% <u>co-insurance</u>	None
	Physician/surgeon fees	<u>Deductible</u> then 30% <u>co-insurance</u>	<u>Deductible</u> then 50% <u>co-insurance</u>	
If you need immediate medical attention	Emergency room services	Medical emergency: <u>Deductible</u> then \$200 <u>co-pay/visit</u> plus 30% <u>co-insurance</u> Medical non-emergency: <u>Deductible</u> then \$200 <u>co-pay/visit</u> plus 30% <u>co-insurance</u>	Medical emergency: <u>Deductible</u> then \$200 <u>co-pay/visit</u> plus 30% <u>co-insurance</u> Medical non-emergency: <u>Deductible</u> then \$200 <u>co-pay/visit</u> plus 50% <u>co-insurance</u>	<u>Co-pay</u> waived if admitted.
	<u>Emergency medical transportation</u>	Ground: <u>Deductible</u> then 30% <u>co-insurance</u> Air: <u>Deductible</u> then 30% <u>co-insurance</u>	Ground: <u>Deductible</u> then 30% <u>co-insurance</u> Air: <u>Deductible</u> then 30% <u>co-insurance</u>	Limited to nearest facility able to treat condition. Air covered if ground medically or physically inappropriate. Non-participating air based on 200 percent of Medicare allowance.
	<u>Urgent care</u>	\$35 <u>co-pay</u> , <u>deductible</u> does not apply	<u>Deductible</u> then 50% <u>co-insurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	<u>Deductible</u> then 30% <u>co-insurance</u>	<u>Deductible</u> then 50% <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. <u>Preauthorization</u> required for some inpatient services.
	Physician/surgeon fees	<u>Deductible</u> then 30% <u>co-insurance</u>	<u>Deductible</u> then 50% <u>co-insurance</u>	None

Common Medical Event	Services You May Need	Participating Provider (You will pay the least)	Non-participating Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$35 <u>co-pay</u> , <u>deductible</u> does not apply	<u>Deductible</u> then 50% <u>co-insurance</u>	None
	Inpatient services	<u>Deductible</u> then 30% <u>co-insurance</u>	<u>Deductible</u> then 50% <u>co-insurance</u>	<u>Preauthorization</u> required.
If you are pregnant	Office visits			<u>Cost sharing</u> does not apply to certain preventive services. 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.
	Childbirth/delivery professional services	<u>Deductible</u> then 30% <u>co-insurance</u>	<u>Deductible</u> then 50% <u>co-insurance</u>	
	Childbirth/delivery facility services			
If you need help recovering or have other special health needs	<u>Home health care</u>	<u>Deductible</u> then 30% <u>co-insurance</u>	<u>Deductible</u> then 50% <u>co-insurance</u>	Limited to 130 visits/year. No coverage for private duty nursing or custodial care. <u>Preauthorization</u> required.
	<u>Rehabilitation services</u>	Inpatient: <u>Deductible</u> then 30% <u>co-insurance</u> Outpatient: <u>Deductible</u> then 30% <u>co-insurance</u>	Inpatient: <u>Deductible</u> then 50% <u>co-insurance</u> Outpatient: <u>Deductible</u> then 50% <u>co-insurance</u>	<u>Preauthorization</u> required. No coverage for recreation therapy. Inpatient: Limited to 30 days/year, additional visits may be preauthorized. Outpatient: Limited to 30 visits/year, additional visits may be preauthorized.
	<u>Habilitation services</u>	Inpatient: <u>Deductible</u> then 30% <u>co-insurance</u> Outpatient: <u>Deductible</u> then 30% <u>co-insurance</u>	Inpatient: <u>Deductible</u> then 50% <u>co-insurance</u> Outpatient: <u>Deductible</u> then 50% <u>co-insurance</u>	<u>Preauthorization</u> required. No coverage for recreation therapy. Inpatient: Limited to 30 days/year, additional visits may be preauthorized. Outpatient: Limited to 30 visits/year, additional visits may be preauthorized.
	<u>Skilled nursing care</u>	<u>Deductible</u> then 30% <u>co-insurance</u>	<u>Deductible</u> then 50% <u>co-insurance</u>	Limited to 60 days/year. No coverage for custodial care. <u>Preauthorization</u> required.

Common Medical Event	Services You May Need	Participating Provider (You will pay the least)	Non-participating Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	<u>Durable medical equipment</u>	<u>Deductible</u> then 30% <u>co-insurance</u>	<u>Deductible</u> then 50% <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. <u>Preauthorization</u> required if equipment is over \$800 and for power-assisted wheelchairs.
	<u>Hospice services</u>	<u>Deductible</u> then 30% <u>co-insurance</u>	<u>Deductible</u> then 50% <u>co-insurance</u>	<u>Preauthorization</u> required. No coverage for private duty nursing.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered
	Children's glasses	Not covered	Not covered	Not covered
	Children's dental check-up	Not covered	Not covered	Not covered

Excluded Services & Other Covered Services:

Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u>.)		
<ul style="list-style-type: none"> • Abortion (except in cases of rape, incest or to save the life of the mother) • Bariatric surgery • Cosmetic surgery • Custodial care • Dental care (Adult) 	<ul style="list-style-type: none"> • Dental check-up (Child) • Hearing aids (Adult) • Hearing aids (Child) • Infertility treatment • Long-term care 	<ul style="list-style-type: none"> • Non-emergency care when traveling outside the U.S. • Private-duty nursing • Routine eye care (Adult) • 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 <u>plan</u> document.)		
<ul style="list-style-type: none"> • Acupuncture 	<ul style="list-style-type: none"> • Chiropractic care 	<ul style="list-style-type: none"> • Weight loss program

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 Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov . 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 <http://www.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. Idaho Department of Insurance at 1-800-721-3272 or at doi.idaho.gov.

Does this plan provide Minimum Essential Coverage? Yes.

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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** \$1,700
- **Specialist** \$50 co-pay/visit
- **Hospital (facility)** 30% co-insurance
- **Other** 30% 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*)

Total Example Cost	\$12,800
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In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$1700
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$2500
<u>What isn't covered</u>	
Limits or exclusions	\$60
The total Peg would pay is	\$4,260

Managing Joe's type 2 Diabetes

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

- **The plan's overall deductible** \$1,700
- **Specialist** \$50 co-pay/visit
- **Hospital (facility)** 30% co-insurance
- **Other** 30% 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*)

Total Example Cost	\$7,400
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In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$1165
<u>Copayments</u>	\$1560
<u>Coinsurance</u>	\$392
<u>What isn't covered</u>	
Limits or exclusions	\$55
The total Joe would pay is	\$3,172

Mia's Simple Fracture

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

- **The plan's overall deductible** \$1,700
- **Specialist** \$50 co-pay/visit
- **Hospital (facility)** 30% co-insurance
- **Other** 30% 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*)

Total Example Cost	\$2,500
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In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$1142
<u>Copayments</u>	\$150
<u>Coinsurance</u>	\$490
<u>What isn't covered</u>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,782

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