BONNER COUNTY

mybenefits

Your Employee Benefit Guide to Health & Wellness

2022—2023

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EMPLOYEE CONTRIBUTION RATES

EFFECTIVE OCTOBER 1, 2022

Employee Cost Per Paycheck (24 Paychecks)	Employee	Employee & Spouse	Employee & Child	Employee & Children	Employee & Family
PacificSource Health Plans					
PPO Base	**$62.19**	**$133.59**	**$88.25**	**$119.30**	**$177.05**
PPO Wellness	**$36.25**	**$97.45**	**$58.59**	**$85.20**	**$134.71**
HSA Base	**$46.51**	**$93.65**	**$61.88**	**$83.66**	**$124.13**
HSA Wellness	**$22.83**	**$61.40**	**$35.40**	**$53.22**	**$86.34**
Delta Dental of Idaho					
	$2.50	**$5.00**	**$5.00**	**$5.00**	**$7.50**
Willamette Dental Group					
	$2.50	**$5.00**	**$5.00**	**$5.00**	**$7.50**
United Heritage Vision					
	$0.00	**$2.70**	**$3.09**	**$3.09**	**$6.52**

Voluntary Life/AD&D, Critical Illness, Accident, and Hospital Indemnity Rate Tables—see Content Page for page assignments

WORKING SPOUSE PREMIUM SURCHARGE

If your spouse has group health coverage available through his/her employer and chooses to enroll in the Bonner County medical plan, a Working Spouse Premium Surcharge of $75 per month will apply.

For those enrolling in the HSA medical plan, Bonner County will contribute the following amounts to your Health Savings Account:

Bonner County Health Savings Account Contribution Strategy 2022—2023	**Contribution Amount per Year**	
Individual HSA Funding ($2,000 HSA plan)	**Non-Wellness**	**Wellness**
	$1,500	$1,800
Family HSA Funding ($2,600 HSA plan)		
	$2,500	$2,800

Any employee that does not complete requested identity verification steps for their H.S.A. Bank account within 60 days of becoming eligible forfeits the Bonner County employer funding.

The employee is responsible for ensuring their total annual contribution into their H.S.A. Bank account, including the amount contributed by Bonner County, does not exceed the annual IRS contribution maximums as outlines on page 22.

Please refer to page 22 for more information on HSA contributions and eligible expenses.

ELIGIBLITY & ENROLLMENT

ELIGIBILITY:
All eligible employees working at least 20 hours per week are qualified for group insurance benefits.

You can also enroll the following eligible dependents in the medical, dental, vision and dependent life coverage:

- Your legal spouse .
- Your dependent children up to the age of 26, including step-children, adopted children, children placed with you for adoption, children for whom you are a legal guardian (up to age 19), foster children.

Coverage may be extended to a child named in a Qualified Medical Child Support Order or to a physically or mentally disabled child if the disability occurs before the child reached age 26.

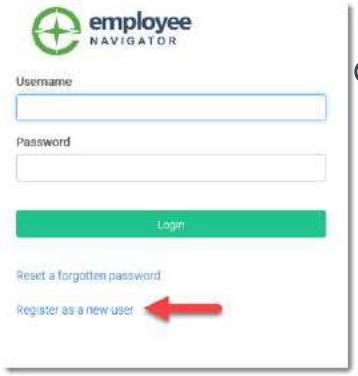
You will have active coverage:

- If you are hired the 1st—15th of the month you will be effective the first of the month following date of hire.
- If you are hired the 16th—last day of the month you will be effective the first of the month following 30 days from your date of hire.

MAKING ENROLLMENT CHANGES DURING THE YEAR:
One you enroll—either as a new hire or during open enrollment—your elections generally stay in effect for the rest of the plan year unless you have a qualifying event that immediately affects your benefit coverage. Examples of qualifying events include:

- Change in martial status;
- Change in number of dependents, birth, adoption, or placement for adoption;
- Change in employment status;
- Dependent satisfies or ceases to satisfy dependent eligibility requirements;
- Residence change; and
- Gain or loss of eligibility for Medicaid or Children's Health Insurance Program.

Please contact HR immediately if you have a status change that could affect your enrollment options.



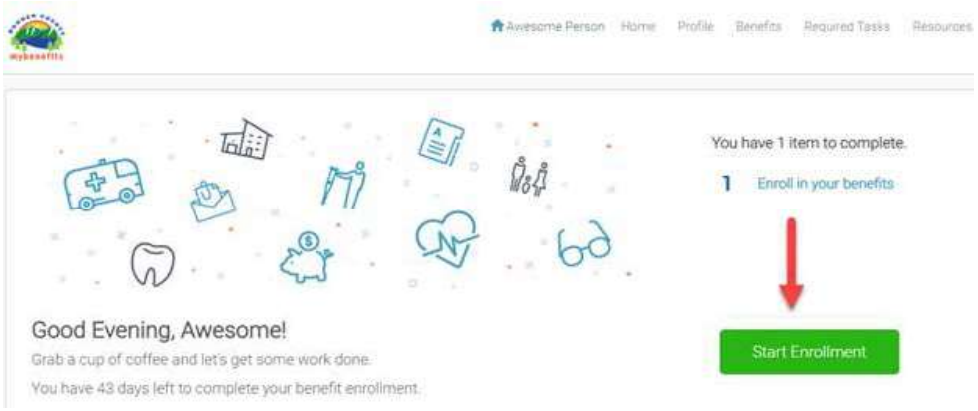
Step 1: Register (Re-registration may be required!)

Go to **https://employeenavigator.com/benefits/Account/Login**

- **Returning users:** If you have logged into Employee Navigator before, please log in with your current username & password.
- **First time users**: Click on your Registration Link in the email sent to you by your admin or **Register as a new user.** Create an account, and create your own username and password.
- COMPANY ID: **BonnerCounty**

Step 2: Welcome!

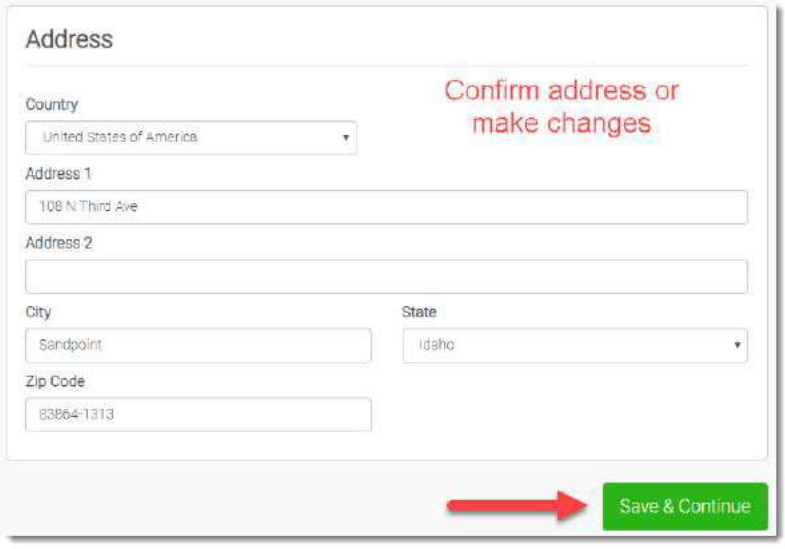
After you login click Start Enrollment.



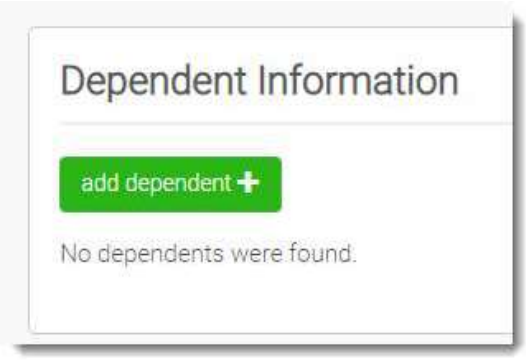
TIP:

If using Passive Enrollment, click Complete HR Task to acknowledge rather than Start Enrollment!

Step 3: Update / Confirm Address



Step 4: Add Dependents



TIP

Have dependent details handy. To enroll a dependent in coverage you will need their date of birth and Social Security number.

Step 5: Benefit Elections

To enroll dependents in a benefit, click the checkbox next to the dependent's name under **Who am I enrolling?**

Below your dependents you can view your available plans and the cost per pay. To elect a benefit, click **Select Plan** underneath the plan cost.

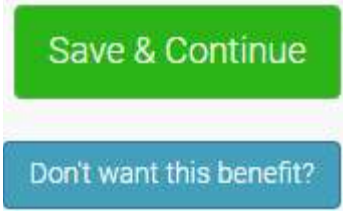
Progress Bar:

Green is complete

Yellow needs an election or a decline

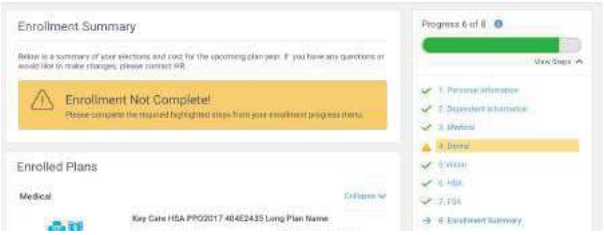
Click **Save & Continue** at the bottom of each screen to save your elections.

If you do not want a benefit, click **Don't want this benefit?** at the bottom of the screen and select a reason from the drop-down menu.



Step 6: Forms

If you have elected benefits that require a beneficiary designation, Primary Care Physician, or completion of an Evidence of Insurability form, you will be prompted to add in those details.



Step 7: Review & Confirm Elections

Review the benefits you selected on the enrollment summary page to make sure they are correct then click **Sign & Agree** to complete your enrollment. You can either print a summary of your elections for your records or login at any point during the year to view your summary online.

TIP

If you miss a step you'll see **Enrollment Not Complete** in the progress bar with the incomplete steps highlighted. Click on any incomplete steps to complete them.

BONNER COUNTY mybenefits

You can login to review your benefits 24/7

small changes big REWARDS

SCHEDULE MY YEARLY PHYSICAL (PREVENTIVE VISIT)
DATE:_____TIME:_____

SCHEDULE MY YEARLY DENTAL EXAMS (PREVENTIVE VISITS)
DATE:_____TIME:_____

SCHEDULE MY YEARLY EYE EXAM (PREVENTIVE VISIT)
DATE:_____TIME:_____

2022-2023 WELLNESS PROGRAM CHECKLIST

COMPLETE MY "KNOW YOUR NUMBERS" ON THE WELLNESS PORTAL

COMPLETE MY BIOMETRIC SCREENING WITH LAB WORK

COMPLETE MY ANNUAL WELLNESS EXAM

COMPLETE MY TOBACCO ATTESTATION FORM & CLASSES (IF NECESSARY)

SUBMIT MY COMPLETED FORMS TO WELLWORKS FOR YOU

EARN MY PREMIUM DISCOUNT & HSA / HRA CONTRIBUTIONS!

Wellworks For You:
www.wellworksforyoulogin.com
forms@wellworksforyou.com
(800)425-4657

NEW USER?
- Go to www.wellworksforyoulogin.com
- Click the link to creat an account as a new Member
- Enter the Company ID (can be found in the Wellness Program flier or you may contact HR)
- Complete the registration process

You can download and print the Wellness Forms from thewebsite or you can contact HR at mybenefits@bonnercountyid.gov.
See page 35 for more information on the Wellness Program.

HEALTH INSURANCE

A PPO Network medical plan allows you to see any provider without a physician referral. The level of benefits you receive is dependent upon your choice of an In-Network provider or an Out-of-Network provider. Significantly higher benefits will be received when you obtain care from an In-Network provider.

Bonner County recognizes that everyone has different medical benefit needs so they offer three medical plans through PacificSource Health Plans using their Voyager (PPO) Network. To find a provider, visit pacificsource.com/find-a-provider.

Plan Year Deductible: Amounts in excess of the allowed amount do not count toward the deductible. No one member will be required to meet more than the individual deductible amount toward the family deductible in a plan year before this plan begins to pay his/her covered services, and this plan will begin to pay the coinsurance percentage for all members' covered services when the family deductible is met.
The deductible starts over October 1st.

Plan Year Out-of-Pocket Maximum: Once your deductible has been satisfied, you will pay 20% while the plan pays 80% for In-Network covered services until you've reached your Out-of-Pocket Maximum at which time the plan will pay 100% for In-Network covered services.
The Out-of-Pocket Maximum starts over October 1st.

Medical Benefit Description *In-Network Coverage Shown*	**Copay Plan**	**HSA $2,000 Individual Plan**	**HSA $2,800 Family Plan**
Deductible	$1,500 Ind / $3,000 Fam	$2,000	$2,800 Ind / $5,200 Fam
Coinsurance	20%	20%	20%
Out-of-Pocket Maximum (includes deductible)	$6,250 Ind / $12,500 Fam	$5,000	$5,000 Ind / $10,000 Fam
Physician Office Visit (Primary/Specialist)	$30 / $45 Copay	Deductible + Coinsurance	Deductible + Coinsurance
Preventive Care Services	No Charge	No Charge	No Charge
Diagnostic X-ray & Laboratory	Deductible + Coinsurance	Deductible + Coinsurance	Deductible + Coinsurance
Urgent Care	$30 Copay	Deductible + Coinsurance	Deductible + Coinsurance
Emergency Room	Deductible + $100 Copay + Coinsurance	Deductible + Coinsurance	Deductible + Coinsurance
Rehabilitation *In-Patient: 30 day limit per Calendar Year; Out-Patient: 30 day limit per Calendar Year*	Deductible + Coinsurance	Deductible + Coinsurance	Deductible + Coinsurance
Hospitalization	Deductible + Coinsurance	Deductible + Coinsurance	Deductible + Coinsurance
Chiropractic Care—*20 Visit Limit*	Coinsurance Applies (Deductible Waived)	Deductible + Coinsurance	Deductible + Coinsurance
Prescription Drug Coverage (Retail)			
Rx Deductible	$250 Ind / $500 Fam (waived for Tier 1)	Medical Deductible Applies (Waived for Preventive RX)	Medical Deductible Applies (Waived for Preventive RX)
Tier 1	$15 Copay	20%	20%
Tier 2	$30 Copay	20%	20%
Tier 3	$45 Copay	20%	20%
Tier 4	$200 Copay	$200 Copay	$200 Copay
Maximum Day Supply	Tier 1—3: 90 Days Tier 4: 30 Days	Tier 1—3: 90 Days Tier 4: 30 Days	Tier 1—3: 90 Days Tier 4: 30 Days

Out of Area Benefits—First Choice Health Program
Individuals on the PacificSource plan are able to receive the In-Network level of benefits while traveling or living outside of Idaho. If you live or or traveling outside of ID, MT, OR or select WA counties (Clark, Cowlitz, Klickitat, Pacific, Skamania, and Wahkiakum) use one of these networks:

⇒ Alaska & Washington (except above noted counties): First Choice Network
⇒ All other states: First Health Network

Value Based Preventive Drug List

The Value Based Preventive Drug List is an optional benefit for self-funded groups. With this benefit, the drugs listed below are covered at 100%.* This list is a separate benefit from preventive drugs covered under the Affordable Care Act. A full list of covered drugs can be found at PacificSource.com/find-a-drug.

Show your PacificSource ID each time you purchase prescriptions at an in-network pharmacy to ensure you're receiving the best benefit.

If you have questions, please email our Customer Service team at cs@pacificsource.com, or call toll-free:

- Idaho: 800-688-5008
- Montana: 877-590-1596
- Oregon: 888-977-9299
- Washington: 866-556-1224
- TTY 711

Asthma

- Arnuity Ellipta
- Flovent Diskus
- Flovent HFA
- Pulmicort FlexHaler
- Qvar RediHaler

Bone health

- alendronate sodium
- ibandronate sodium

Cholesterol

- atorvastatin calcium
- lovastatin
- pravastatin sodium
- simvastatin

Mental health

- bupropion HCL
- carbamazepine
- citalopram HBR
- fluoxetine HCL
- imipramine HCL
- lithium carbonate
- nortriptyline HCL
- olanzapine
- paroxetine HCL
- quetiapine fumarate
- risperidone
- sertraline HCL
- venlafaxine HCL

Heart/blood pressure

- acebutolol HCL
- amiloride-HCTZ
- amlodipine besylate
- amlodipine besylate-benazepril
- atenolol
- atenolol-chlorthalidone
- benazepril HCL
- benazepril HCTZ
- bisoprolol fumarate
- bisoprolol-HCTZ
- bumetanide
- captopril
- chlorothiazide
- chlorthalidone
- clonidine HCL
- diltiazem ER
- diltiazem HCL
- enalapril maleate
- enalapril-HCTZ
- felodiprine ER
- fosinopril sodium
- fosinopril-HCTZ
- furosemide
- guanfacine HCL
- hydrochlorothiazide
- indapamide
- irbesartan
- irbesartan-HCTZ
- isradipine
- labetalol HCL
- lisinopril
- lisinopril-HCTZ
- losartan potassium
- losartan-HCTZ
- methyclothiazide
- metolazone
- metoprolol tartrate
- metoprolol-HCTZ
- moexipril-HCL
- nadolol
- nicardipine HCL
- nifedipine ER
- pindolol
- propranolol HCL
- propranolol-HCTZ
- quinapril HCL
- spironolactone
- spironolactone-HCTZ
- torsemide
- trandolapril
- triamterene-HCTZ
- valsartan-HCTZ
- verapamil ER
- verapamil ER PM
- verapamil HCL

Continued >

Diabetes

- Acarbose
- Apidra*
- Baqsimi
- Farxiga*
- Fiasp FlexTouch
- Fiasp
- glimepiride
- glipizide
- glipizide ER
- glipizide XL
- glipizide-metformin
- GlucaGen
- Glucagon
- Glyburide
- Glyburide-Metformin
- Glyxambi*
- Gvoke
- HumuLIN
- Janumet*
- Janumet XR*
- Januvia*
- Jardiance*
- Lantus Solostars
- Lantus
- Levemir FlexTouch
- Levemir
- metformin HCL
- metformin HCL ER
- miglitol
- nateglinide
- NovoLIN 70/30 FlexPen
- NovoLIN 70/30 Suspension
- NovoLIN N
- NovoLIN R
- NovoLOG
- Omnipod
- Omnipod Dash
- Ozempic*
- pioglitazone
- repaglinide
- Rybelsus*
- Synjardy*
- Synjardy XR*
- Toujeo Max Solostar
- Toujeo Solostar
- Tresiba FlexTouch
- Tresiba
- Trijardy XR*
- Trulicity*
- Victoza*
- Xigduo XR*

*Preauthorization or step therapy may apply. Preauthorization means we review the drug request to ensure it meets certain criteria. Step therapy means we may ask you to try a different drug first before reviewing the request. Both processes help us deliver safe and effective care.

Diabetic testing:

- BD Insulin Syringe
- BD Pen Needle
- Dexcom G6 (Receiver, Sensor, Transmitter)*
- FreeStyle Libre 14 Day (Reader, Sensor)*
- FreeStyle Libre (Reader, Sensor)*
- FreeStyle LIbre 2 (Reader, Sensor)*
- OneTouch Lancets
- OneTouch Ultra Blue Strips
- OneTouch Verio Strips

PacificSource Incentive Drug List

Effective January 1, 2019

The Incentive Drug List is offered to select large employer groups. The drugs listed below are available for the incentive copay shown on your policy or pharmacy summary of benefits. This is a partial list of covered drugs, and includes only those offered at the incentive copay rate. A full list of covered drugs can be found on our website at **PacificSource.com/drug-list.**

If you are taking a drug for a chronic condition and the drug is not listed below, consider asking your doctor about switching to one of these incentive alternatives to reduce your out-of-pocket costs. Show your PacificSource ID card each time you purchase prescriptions at an in-network pharmacy to ensure you're receiving the best benefit.

Unless otherwise noted, incentive drugs are limited to short-acting drugs. Long-acting drugs, transdermal patches, suspensions, compounds, and injectable drugs are not typically on the Incentive Drug List.

If you have questions, please email our Customer Service Department at **cs@pacificsource.com,** or call toll-free:

- (800) 688-5008 in Idaho
- (877) 590-1596 in Montana
- (888) 977-9299 in Oregon
- (866) 556-1224 in Washington

Antidepressants

- bupropion SR, XL
- citalopram
- fluoxetine capsule
- imipramine
- nortriptyline
- paroxetine
- sertraline
- trazodone
- venlafaxine

Anticonvulsants

- carbamazepine 200mg tab

Antidiabetic Agents

- glimepiride
- glipizide
- glipizide ER
- glipizide/metformin
- glyburide
- insulin syringes and needles
- metformin
- metformin ER

Antivirals

- acyclovir

Mental Health

- lithium carbonate
- olanzapine
- quetiapine
- risperidone

Cholesterol Lowering Drugs–Hyperlipidemics

- atorvastatin
- fenofibrate
- gemfibrozil
- lovastatin
- pravastatin
- simvastatin

Blood Pressure Lowering and Cardiac Drugs – Antihypertensives

- acebutolol
- amiloride/HCTZ
- amlodipine
- amlodipine/benazepril
- atenolol
- atenolol/chlorthalidone
- benazepril
- benazepril/HCTZ
- bisoprolol
- bisoprolol/HCTZ
- bumetanide
- captopril
- chlorothiazide
- chlorthalidone
- clonidine
- diltiazem ER
- enalapril
- enalapril/HCTZ
- felodipine ER
- fosinopril
- fosinopril/HCTZ
- furosemide
- guanfacine
- hydrochlorothiazide (HCTZ)
- indapamide
- irbesartan
- isradipine
- labetalol
- lisinopril
- lisinopril/HCTZ
- losartan
- losartan/HCTZ
- methyclothiazide
- metolazone
- metoprolol ER
- metoprolol tartrate
- metoprolol/HCTZ
- moexipril
- nadolol
- nicardipine
- nifedipine ER
- pindolol
- propranolol
- propranolol/HCTZ
- quinapril
- spironolactone
- spironolactone/HCTZ
- torsemide
- trandolapril
- triamterene/HCTZ
- valsartan/HCTZ
- verapamil
- verapamil ER tablet

Endocrine/Thyroid

- levothyroxine

PREVENTIVE BENEFIT LIST

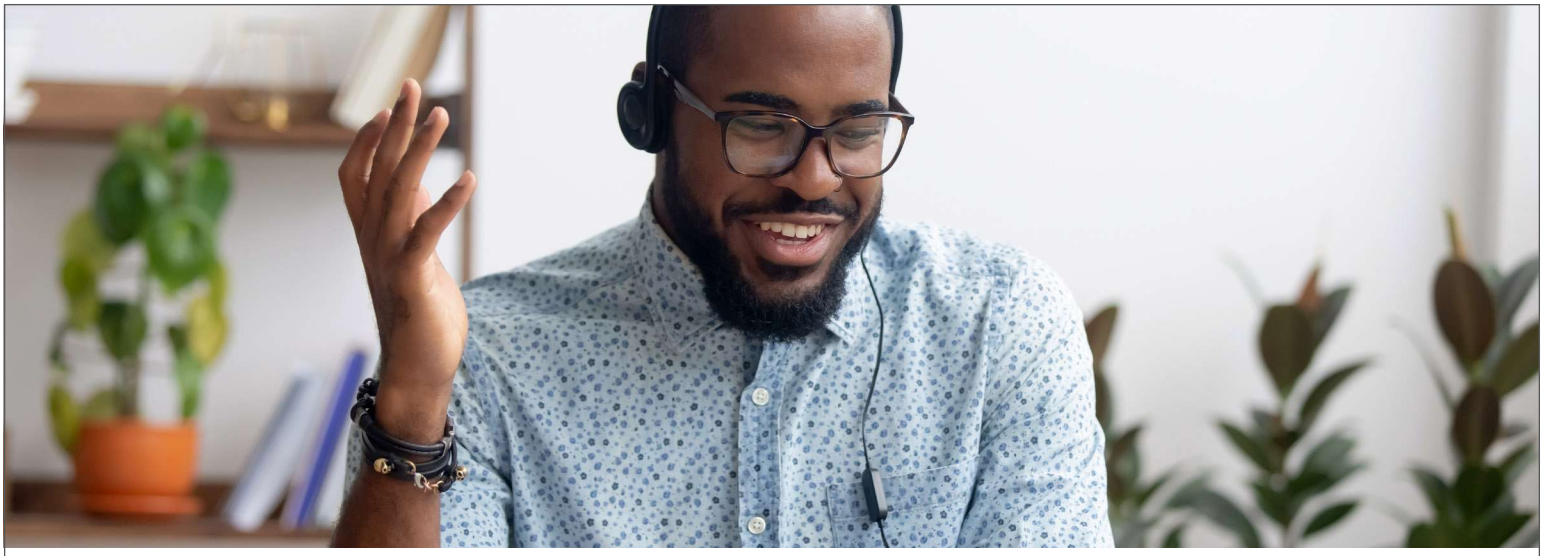
Using your preventive care benefits is a good way to maintain and even improve your health. When these services are given by a participating provider and billed as routine preventive services, your plan covers them in full. This is true even if you have not met your annual deductible.

Preventive Care Services and Limits	
Well baby/Well child care	For members age 21 and younger according to the following schedule: - At birth: One standard in-hospital exam - Ages 0-2: 12 additional exams during the first 36 months of life - Ages 3-21: One exam per calendar year
Routine physicals	Including appropriate screening radiology and laboratory tests and other screening procedures for members age 22 and older are covered once per calendar year. Screening exams and laboratory tests may include, but are not limited to, blood pressure checks, weight checks, occult blood tests, urinalysis, complete blood count, prostate exams, cholesterol exams, stool guaiac screening, EKG screens, blood sugar tests, and tuberculosis skin tests. Only laboratory tests and other diagnostic testing procedures related to the routine physical exam are covered by this benefit. Any laboratory tests and other diagnostic testing procedures ordered during, but not related to, a routine physical examination are not covered by this preventive care benefit.
Well woman visits	Include the following: - One routine gynecological exam each calendar year for women 18 and over. Exams may include Pap smear, pelvic exam, breast exam, blood pressure check, and weight check. Covered lab services are limited to occult blood, urinalysis, and complete blood count. - Pelvic exams and Pap smear exams for women 18 to 64 years of age annually, or at any time when recommended by a women's healthcare provider. - Breast Exams annually for women 18 years of age or older or at any time when recommended by a women's healthcare provider for the purpose of checking for lumps and other changes for early detection and prevention of breast cancer. Members have the right to seek care from obstetricians and gynecologists for covered services without preapproval or preauthorization.
Routine mammograms	Routine preventive mammograms for women as recommended
Contraceptives	Any deductible, co-payment, and/or co-insurance amounts are waived for Food and Drug Administration (FDA) approved contraceptive methods for all women with reproductive capacity, as supported by the Health Resources and Services Administration (HRSA), when provided by a participating pharmacy. If a generic exists, preferred brand contraceptives will remain subject to regular pharmacy plan benefits unless deemed medically necessary by the member's attending provider. Providers must request formulary exceptions by contacting our Pharmacy Services team. When no generic exists, preferred brands are covered at no cost. If a generic becomes available, the preferred brand will no longer be covered under the preventive care benefit unless deemed medically necessary by the member's attending provider.
Sterilization	Tubal ligation and vasectomy are covered procedures. Vasectomy procedures may be subject to the deductible on some plans.
Breastfeeding	Manual and electric breast pumps are covered at no cost once per pregnancy when purchased or rented from a participating licensed provider, or purchased from a retail outlet. Hospital-grade breast pumps are not covered.
Immunizations	Age-appropriate childhood and adult immunizations for primary prevention of infectious diseases as recommended and adopted by the Centers for Disease Control and Prevention, American Academy of Pediatrics, American Academy of Family Physicians, or similar standard-setting body. Benefits do not include immunizations for more elective, investigative, unproven, or discretionary reasons (e.g. travel). Covered immunizations include but may not be limited to the following: - Diphtheria, pertussis, and tetanus (DPT) vaccines, given separately or together - Hemophilus influenza B vaccine - Hepatitis A vaccine

PREVENTIVE BENEFIT LIST

Preventive Care Services and Limits	
	- Hepatitis B vaccine - Human papillomavirus (HPV) vaccine - Influenza virus vaccine - Measles, mumps, and rubella (MMR) vaccines, given separately or together - Meningococcal (meningitis) vaccine - Pneumococcal vaccine - Polio vaccine - Shingles vaccine for ages 60 and over - Varicella (chicken pox) vaccine
Routine Colonoscopy	Colorectal cancer screening exams and lab work including the following: - A fecal occult blood test - A flexible sigmoidoscopy - A colonoscopy - A double contrast barium enema A colonoscopy performed for routine screening purposes is considered to be a preventive service.
Prostate cancer screening	Including a digital rectal examination and a prostate-specific antigen test.
Tobacco cessation program services	Tobacco cessation program services and drugs are covered at no charge. Prescribed tobacco cessation related medication will be covered to the same extent this policy covers other prescription medications.
Pharmacy	Unless otherwise stated, a written prescription is required, even if the covered drug is over-the-counter. A 90-day supply is allowed at both participating retail and mail-order pharmacies, unless otherwise noted. - Aspirin to prevent cardiovascular disease and colorectal cancer for ages 50 to 59 and as a preventive medication after 12 weeks of gestation in women who are at high risk of preeclampsia; generic 81mg only. - Low to moderate dose generic statin to prevent cardiovascular disease for age 40 to 75 - Fluoride through age 5 years only - Folic Acid supplements for women under 55 who are planning or capable of pregnancy - Vitamin D supplementation to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls - Raloxifene and Tamoxifen to reduce primary breast cancer risk in females age 35 and over - Bowel preparation medications for ages 50 through 74 years; Gavilyte-H kit, etc. - Tobacco cessation medications as prescribed by a doctor: o OTC (gum, patches, lozenges) or prescription tobacco cessation medications (bupropion, Zyban, or Chantix) when purchased at a participating pharmacy o 168 day annual limit on tobacco cessation drugs Please note this information is reviewed and updated periodically. For the most current information, please visit the website below.
Other Medical	- Services that have a rating of 'A' or 'B' from the U.S. Preventive Services Task Force (USPSTF) - Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC) - Preventive care and screening for infants, children, and adolescents supported by the Health Resources and Services Administration (HRSA) - Preventive care and screening for women supported by the HRSA that are not included in the USPSTF recommendations A and B lists for preventive services can be found at: http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ The list of Women's preventive services can be found at: http://www.hrsa.gov/womensguidelines/

This is a brief summary. Refer to the benefit policy for more details on benefits, limits, and exclusions.



Member Support Specialists

Connecting you with the care you deserve

When it comes to great service, our Member Support Specialists go above and beyond to give you the care you deserve. They work hard to remove roadblocks, and help members through the often-complicated world of healthcare.

Here's a sample of some of the ways Member Support Specialists help PacficSource members with their needs:

Basic needs

Housing—Help connecting you with ways to pay rent, mortgage, or other housing-related costs.

Food—Help arranging meal delivery services to keep members from going hungry.

Transportation—Help getting rides to and from doctor's appointments.

Utilities—Help getting clean water, electricity, or heat by connecting you with aid for utility bills, firewood, and more.

Medical help

Finding a doctor—Help finding the right doctor for your medical needs.

Appointments—Working with your doctors to help you schedule appointments and provide helpful reminders.

Follow-through—Arranging home care, prescriptions, and treatment plans.

Equipment—Help getting all the things you need to help with your medical care, from crutches to wheelchairs to CPAP machines to blood glucose monitors.

More extraordinary help

- Wheelchair ramps
- Yard cleanup
- Service dogs
- Translation
- Assistance with copays
- Support groups
- Incontinence supplies
- Help with Social Security disability insurance
- A better understanding of insurance benefits
- More information about your medical conditions

Free and confidential

Choosing to work with a Member Support Specialist is completely up to you. There is no obligation or cost to participate. And your interaction will remain confidential. No need is deemed too great or small.

Find out more

If you have questions or want to sign up, please call a Member Support Specialist Monday-Friday, 8:00 a.m. - 5:00 p.m. at:

Phone

Toll-free

Medicare members call:
888-862-9725

All other members call:
888-691-8209

TTY (800) 735-2900

24-Hour NurseLine

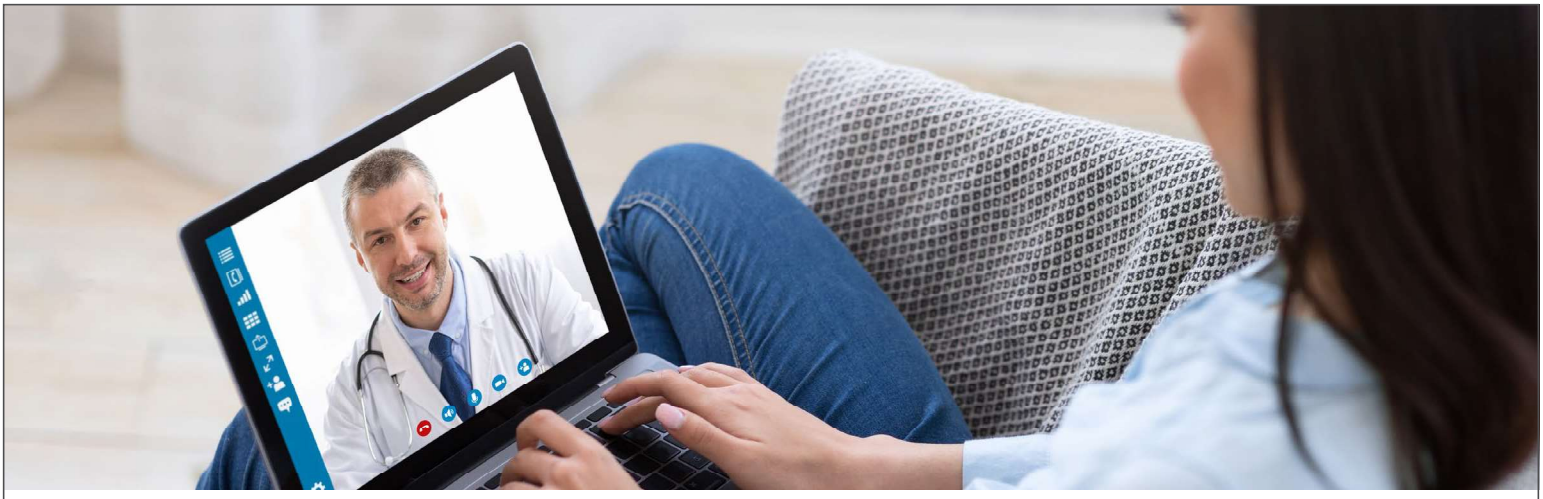
Toll-free

(855) 834-6150

TTY (844) 514-3774

PacificSource.com

PacificSource



Teladoc®—access to doctors via phone, video, or mobile app

As a PacificSource member,* you have on-demand access to board-certified doctors 24 hours a day, 7 days a week.

Here's how to get started and what you need to know.

1. Set up your Teladoc account

There are three options to get started. Note: when asked to enter the name of your employer or insurance carrier, please use "**PacificSource**" in the field.

Online: Log in or register with InTouch for Members through PacificSource.com. Find the "Teladoc - Remote Care" link under "Tools" to set up your account.

Mobile app: Visit Teladoc.com/mobile to download the app, then click "Activate account."

Phone: Teladoc can help you register your account over the phone at **855-201-7488.**

2. Provide medical history

This provides Teladoc doctors with the information they need to make an accurate diagnosis.

3. Request an appointment

Once your account is set up, request an appointment any time you need care. And talk to a doctor by phone, web, or mobile app.

*Employer group members: to see if Teladoc is available on your plan, check with your employer or contact PacificSource Customer Service at **888-977-9299**, **TTY 711**, or CS@PacificSource.com.

See reverse for FAQ >

Talk to a doctor anytime!

Web
Teladoc.com

Phone
855-201-7488

Mobile App
Teladoc.com/mobile

PacificSource HEALTH PLANS

Frequently Asked Questions

What is Teladoc?

Teladoc is the first and largest provider of telehealth medical consults in the United States, giving you 24/7/365 access to quality medical care through phone and doctor visits.

Who are the Teladoc doctors?

Teladoc doctors are U.S. board certified in internal medicine, family practice, or pediatrics. They average 20 years practice experience, are licensed in your state, and incorporate Teladoc into their day-to-day practice as a way to provide people with convenient access to quality medical care.

Does Teladoc replace my doctor?

No. Teladoc does not replace your primary care physician. Teladoc should be used when you need immediate care for nonemergent medical issues. It is an affordable, convenient alternative to urgent care and ER visits.

What kind of medical care does Teladoc provide?

Teladoc provides general medical care for adults and children, and behavioral healthcare for adults. Examples of common medical conditions Teladoc can address include: sinus problems, pink eye, bronchitis, allergies, flu, ear infections, urinary tract infections, and upper respiratory infections.

What consult methods are available?

You can talk with a general medical Teladoc doctor via a phone consult, video consult within the secure member portal, or video consult within the Teladoc mobile app. Behavioral health visits are available via video only.

How do I set up my Teladoc account?

You can set up your account through InTouch at PacificSource.com, or through the Teladoc website or mobile app. You can also call Teladoc to get started. Note: if setting up your account online, enter "**PacificSource**" for the name of your employer or insurance carrier.

How do I request a consult to talk to a doctor?

Visit the Teladoc website, log into your account, and click "Request a Consult." You can also call Teladoc to request a general medical consult by phone. Behavioral health appointments can be scheduled online or through our mobile app.

How do I request a behavioral health visit?

Behavioral health visits are scheduled and occur via the Teladoc website or mobile app. Log into your account, complete a quick assessment, and choose your therapist. Provide three options of times you are available for an appointment. The therapist will reach out to you to schedule the appointment.

How quickly can I talk to the doctor?

The median call back time for a general medical request is just 10 minutes. If you miss the doctor's call, whether you are away from the phone or you have anonymous call blocker on, you will be returned to the bottom of the waiting list. The consult request is cancelled if you miss three calls.

Is there a time limit when talking with a doctor?

There is no time limit for consults.

Can Teladoc doctors write a prescription?

Yes. Teladoc doctors can prescribe short-term medication for a wide range of conditions when medically appropriate. Teladoc doctors do not prescribe substances controlled by the DEA, nontherapeutic, and/or certain other drugs, which may be harmful because of their potential for abuse.

How do I pay for a prescription called in by Teladoc?

When you go to your pharmacy of choice to pick up the prescription, you may use your health/prescription insurance card to help pay for the medication. The exact amount you will pay is based on the type of medication and your plan benefits.

Is the consult fee the same price, regardless of the time?

The exact amount you will pay is based on your specific plan benefits. The amount for a telehealth visit is shown on your summary of benefits.

How do I pay for the consult?

You can pay with your HSA (health savings account) card, credit card, prepaid debit card, or by PayPal. Your account will be charged at the time of the visit. Your payment method will be set up when you register for Teladoc, and can be changed anytime.

If the Teladoc doctor recommends that I see my primary care physician or a specialist, do I still have to pay the Teladoc consult fee?

Yes. Just like any doctor appointment, you must pay for the consulting doctor's time.

Can I provide consult information to my doctor?

Yes. You have access to your electronic medical record at anytime. Download a copy online from your account or call Teladoc and ask to have your medical record mailed or faxed to you.

PacificSource HEALTH PLANS

Value-added extras for you

Our extra tools, benefits, and programs are how we add value to your health plan. These extras help you make the most of your plan and live a healthier life. You can find more information about these programs and services at PacificSource.com/extras.

Wellness programs

24-Hour NurseLine

You'll never be without a registered nurse to talk to when you have health-related questions. To talk to a nurse, call toll-free: **855-834-6150.**

Tobacco cessation

Our Quit For Life® program, brought to you by Optum, offers one-on-one treatment sessions with a professional Quit Coach to help tobacco users kick the habit. Prescription medications are also available, when prescribed by your doctor.

Health and wellness education

Receive up to $150 reimbursement per year for health and wellness education classes in your area.

Prenatal Program

Our Prenatal Program helps expectant mothers learn more about their pregnancy and the development of their child. Participants receive educational materials and phone support from a nurse consultant. High-risk members receive additional support through a specialized program.

Prenatal vitamins

Women between the ages of 15 and 50 with prescription drug coverage can receive physician-prescribed prenatal vitamins at no cost—all copays and deductibles are waived—when filled through an in-network pharmacy. Visit PacificSource.com/prenatal to find out which prenatal vitamins are covered.

Weight management programs

As a part of your PacificSource medical coverage, participate in a WW® (formerly Weight Watchers) program and receive an annual reimbursement of $100 ($40 if an online WW participant) for your WW membership. Complete a minimum of ten weeks during a consecutive four-month period to maintain eligibility.

Discounted gym membership

Active&Fit Direct™ gives you access to more than 9,000 fitness facilities nationwide. The program's website offers a gym locator, educational materials, online fitness tracking, and wellness product discounts.

Email
CS@PacificSource.com

Phone
888-977-9299
TTY: 711
We accept all relay calls.
En Español 866-281-1464

PacificSource.com

PacificSource HEALTH PLANS

Wellness for kids

Six- and nine-year-olds currently covered by a PacificSource medical plan can join HealthKicks!, a children's program that promotes healthy behaviors.

Children enrolling in HealthKicks! will receive age-appropriate, educational activity sheets in the mail with fun information on topics such as nutrition, exercise, and good health habits.

Travel emergency assistance program

Assist America® Global Emergency Services

If you experience a medical emergency while traveling 100 or more miles from home or abroad, you can access services provided by Assist America at no cost. Services include medical consultation and evaluation, medical referrals, foreign hospital admission guarantee, critical care monitoring, and when medically necessary, evacuation to a facility that can provide treatment.

Pharmacy

Rx delivery by mail

We partner with CVS Caremark® for home delivery by mail. If your plan includes prescription drug coverage, the mail delivery service is a convenient and cost-saving option. Visit PacificSource.com/members/prescription-drug-information.

CVS Caremark
Web: Caremark.com
Phone: 866-329-3051

Care management

Condition support program

Personal support is available to members with certain chronic conditions. If you have diabetes, coronary artery disease, heart failure, chronic obstructive pulmonary disease (COPD), or asthma, you might be interested in our free condition support program. It is optional and includes one-on-one coaching with our nurses and dietitian to help you reach your health and wellness goals.

Rare disease support

Our AccordantCare Rare Disease Program provides ongoing one-on-one support and care coordination to people with certain chronic, rare conditions. The program helps ensure optimal care, decrease complications, and improve health outcomes.

Specialty medication support

Members with conditions that require injectable medications and biotech drugs can access our specialty pharmacy program through Caremark Specialty Pharmacy Services. A pharmacist-led CareTeam provides individual follow-up care and support.

Case Management Services

If you have an ongoing medical need, our Nurse Case Managers can help. PacificSource Case Managers—registered nurses with extensive experience—work with you and your healthcare providers to ensure continuity of care and prevent breaks in necessary medical services.

Phone and video doctor visits

Teladoc is a national network of U.S. board-certified physicians and pediatricians that you can see on-demand 24/7, via phone or online video consultations, from wherever you happen to be. With most plans, you won't pay anything for a virtual visit with Teladoc. If you have an HSA plan, a virtual visit with Teladoc is subject to deductible. Check your plan summary's telemedicine benefit to confirm your cost share.

Online resources

PacificSource.com offers you a wealth of tools, information, and resources to help you make the most of your benefits.

InTouch: access coverage and benefit information

By logging into InTouch, you can easily and conveniently manage your insurance coverage and health 24/7. Look up coverage information, check the status of a claim, view explanation of benefits (EOB) statements for paid claims, and more.

myPacificSource mobile app

The easiest way to view and manage your benefits while on the go. Available for both iPhone® and Android™. Visit PacificSource.com/mobile.

Health engagement portal

CaféWell is a secure online health engagement portal with personalized information and tools to help you make the most of your health. Log into InTouch, then click Benefits > Wellness – CaféWell.

Provider directory

Our online provider directory makes it easy to find in-network healthcare providers for your plan. You can search by specialty, name, location, or other details to access a listing of providers that fit your criteria. Or, you can create your own personalized provider directory to download and print.

To access the directory, go to PacificSource.com/find-a-doctor.

Find more information at PacificSource.com/extras.

Please note: These value-added programs are not available with all plans. Check with your plan administrator or our Customer Service team for details.

Access Care Nationally

If you travel or live outside the Greater Northwest, reduce your out-of-pocket for quality care across the USA.

Nationwide Coverage

We offer access to care beyond Idaho, Montana, Oregon, and Washington.

Our partners are yours, too: First Health® and First Choice Health™ are national healthcare provider networks powered by physicians, hospitals, and other outpatient care facilities. For medical attention outside your plan's network, you're able to get the care you need.

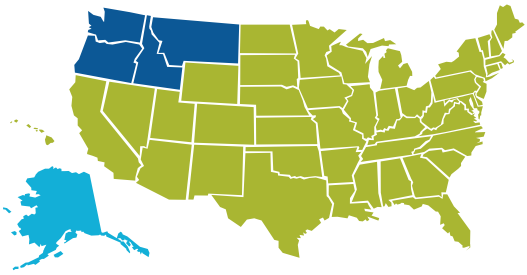
First Choice Health™ Network

Members can access this network when traveling throughout Alaska.

First Health® Network

You can access this network when you are in any other state, except Alaska, Idaho, Montana, Oregon, and Washington.

You will receive your plan's participating level of benefits when you access providers and facilities from these networks for care.



First Choice Health™

First Health©

Access to Providers

Find up-to-date provider information at PacificSource.com/findaprovider. To search First Health and First Choice Health providers, go to the First Health and First Choice Health links just below the U.S. map.

You also can find First Choice Health and First Health providers by phone:

- **First Choice Health**
  (800) 231-6935, ext. 2102
- **First Health**
  (800) 226-5116

Email

cs@pacificsource.com

Phone

Toll-free (888) 977-9299

TTY

Toll-free (800) 735-2900

En Español

Direct (541) 684-5456
Toll-free (866) 281-1464

PacificSource.com

PacificSource HEALTH PLANS

Frequently Asked Questions

What if the provider I want to use is not a member of the network?

If the provider doesn't participate (is not contracted with your plan's network or our travel networks, and a network provider is available in that area), you will receive your plan's out-of-network provider benefits, unless it is a true medical emergency. If you have a true medical emergency, go directly to the nearest emergency room or appropriate facility, and there will be no reduction in benefits.

If you would like to request that a provider join either network, you may contact our Customer Service Department for a nomination form. Give the form to the provider to complete and return to PacificSource. Keep in mind, that sending in a nomination form doesn't mean the provider will automatically be added to the network. The nomination process may take up to nine months, and not all providers are approved.

What if there are no network providers where I live?

The networks are growing and adding new providers all the time. If a network provider is not available where you live, your plan pays your covered expenses based on usual, customary, and reasonable charges for that area.

What if I need nonemergency hospitalization?

You may check with the network for your area to find out if there is a participating hospital nearby. Then, check with your physician to see if he or she has hospital privileges with that hospital. Finally, have your physician preauthorize your admission by calling our Health Services Department at **(888) 691-8209.**

How are my claims paid when I receive treatment?

When you use a First Choice Health or First Health provider, simply show your PacificSource member ID card. The provider will send your claim to us automatically, and you won't have to file any paperwork.

If you go to an out-of-network provider, the provider may or may not bill us directly. If they don't bill us directly, you'll need to pay for the services up front, then send PacificSource a claim for reimbursement. Your claim must include a copy of the provider's itemized bill, along with your name, member ID number, group name and number, and the patient's name. If you were treated for an accidental injury, please also include the date, time, place, and circumstances of the accident.

How do providers obtain information on benefits, preauthorization, and eligibility?

Show your PacificSource member ID card to the provider office when obtaining services. It contains important provider information. For preauthorizations, providers should contact our Health Services Department. Our Customer Service Department can verify benefits and member eligibility for them.

What if I'm traveling in another country?

If you experience a medical emergency while traveling 100 or more miles from home or abroad, you can access services provided by Assist America® Global Emergency Services at no cost. Services include medical consultation and evaluation, medical referrals, foreign hospital admission guarantee, critical care monitoring, and when medically necessary, evacuation to a facility that can provide treatment.

For more information, visit **PacificSource.com.**

PacificSource HEALTH PLANS

HEALTH SAVINGS ACCOUNTS (HSAs)

What is an HSA?

A Health Savings Account is an individually owned, earnings-bearing account to help pay for future qualified medical expenses with tax-free dollars.

Who is eligible for an HSA?

An HSA owner must be enrolled in an HSA-eligible High-Deductible Health Plan (HDHP).

You are NOT eligible if:

You are enrolled in Medicare.
A tax dependent on someone else's tax return.
Have received VA benefits in the last 3 months.
You are enrolled in a non-qualified HDHP plan.

How do I manage my HSA?

Your HSA is your account and the dollars are your dollars. Since you are the account holder, you manage your HSA account. You may choose when to use your HSA dollars or when not to use your HSA dollars. HSA dollars pay for any eligible medical expense.

Opening Your HSA?

An account has been opened on your behalf through Flores and WealthCare Saver Bank.

If you don't want to use Flores, you may open an account on your own through a bank or other financial institution. Banks, credit unions, insurance companies and other financial institutions are all permitted to be trustees or custodians of these accounts.

Contribution Limits

	2022	2023
Employee	$3,650	$3,850
Employee + 1	$7,300	$7,750
Age 55+ Catch Up Contribution	$1,000	$1,000

What expenses are eligible for reimbursement?

HSA dollars may be used for qualified medical expenses incurred by the account holder and his or her spouse and IRS dependents. Qualified medical expenses are outlined within IRS Section 213(d) which states that "the expense has to be primarily for the prevention or alleviation of a physical or mental defect or illness."

In addition to qualified medical expenses, the following insurance premiums may be reimbursed from an HSA:

- COBRA premiums.
- Health insurance premiums while receiving unemployment benefits.
- Qualified long-term care premiums.
- Any health insurance premiums paid, other than for a Medicare supplemental policy, by individuals ages 65 and over.

Are dental and vision care considered qualified medical expenses under an HSA?

Yes, as long as these are deductible under the current rules. For example, cosmetic procedures, like cosmetic dentistry, would not be considered qualified medical expenses.

Can I use my HSA dollars for non-eligible expenses?
Money withdrawn from an HSA account to reimburse non-eligible medical expenses is taxable income to the account holder and is subject to a 20% tax penalty. The exception to this rule is if the account holder is over age 65, disabled, or upon death of the account holder.

When can I start using my HSA dollars?
You can use your HSA dollars immediately following your HSA account activation and once contributions have been made.

When do I contribute to my HSA account, and how often?
You, your employer, or others can contribute to your HSA account through payroll deductions or as a lump sum deposit. You can contribute as often as you like, provided you and your employer's total annual contributions do not exceed the contribution limits shown above.

What if I have HSA dollars left in my account at the end of the year?
The money is yours to keep. It will continue to earn interest and will be available for you and your healthcare costs next year. Any dollars left in your HSA account at
year-end will automatically roll over.

What happens to my HSA dollars if I leave my employer?
The funds are yours to keep! It is your account and you manage it as you see appropriate.

Can I use the money in my account to pay for my dependents' medical expenses?
You can use the money in the account to pay for the medical expenses of yourself, your spouse, and your dependents. You can pay for expenses for your spouse and dependents even if they are not covered by your HDHP.

Who qualifies as a dependent?
A person generally qualifies as your dependent for HSA purposes if you claim them as an exemption on your Federal tax return. Please see IRS publication 502 for exceptions. www.IRS.gov/Pub/irs-pdf/.

Can couples establish a "joint" account and both make contributions to the account, including "catch-up" contributions?
"Joint" HSA accounts are not permitted. Each spouse should consider establishing an account in his or her own name. This allows you to both make catch-up contributions when you are 55 or older.

DENTAL INSURANCE—Delta Dental

Regular dental care is essential to good health. The Bonner County dental plan is administered through Delta Dental of Idaho and Willamette Dental Group. It's designed to provide you with a choice of dental coverage you need with the features you want. Take advantage of what these plans have to offer without compromising what matters most—including the freedom to visit the dentist of you and your dependents choice.

One option for optimal savings is using the Delta Dental plan of Idaho participating dentist or specialist. You can find a dentist by visiting www.deltadentalid.com. You can also call (208) 489-3580. If you choose a dentist who does not participate in our dental plan, your out-of-pocket expenses may be more, since you will be responsible for paying any difference between the dentist's fee and the plan's payment for the approved service.

Delta Dental of Idaho Dental Plan	PPO Dentist	Premier Dentist
Calendar Year Deductible*	$50 Individual / $150 Family	
Calendar Year Benefit Maximum*	$1,250	$1,000
Preventive Care/Diagnostic	100% (Deductible Waived)	80% (Deductible Waived)
Oral Examinations & Cleanings		
Sealants		
Topical Fluoride Application		
Full Mouth & Bitewing X-rays		
Basic Restorative	80%	70%
Endodontics—Root Canal		
General Anesthesia		
Oral Surgery (Simple Extractions)		
Periodontics/Gum Disease		
Major Restorative	50%	40%
Implants: Services		
Implants: Repairs		
Bridges, Dentures, Crowns/Onlays		
Orthodontia	Discounts Available	

**Deductible & Benefit Maximum start over January 1st*

HOW HEALTH through ORAL WELLNESS

Here's [HOW] you can maximize your oral health at no additional cost.

HOW TO GET STARTED:

Simply request a free Health through Oral Wellness (HOW) risk assessment at the beginning of your dental visit with your Delta Provider.

If you qualify based on your results, Delta Dental of Idaho will release, or 'unlock' specifc additional benefts without an increase in premium such as additional cleanings, sealants or periodontal maintenance for example.

DENTAL INSURANCE—Willamette Dental

As well as Delta Dental, Bonner County offers a dual-option dental plan with Willamette Dental Group. Willamette is a coordinated-care network that offers additional savings by allowing you to focus on staying healthy. To Obtain the best benefits of your Willamette Dental plan, you must receive care from a Willamette Dental Group dentist or specialist. You can find dentists by visiting www.willamettedental.com. You can also call 1 (855) 4DENTAL. ***Nearest clinic— 943 W Ironwood Drive #200; Coeur D'Alene***

One difference from this plan compared to the Delta Dental plan is the annual maximum and deductible. Willamette Dental plans have no annual maximum and no deductible. This means you will never exhaust your dental coverage and you don't need to satisfy a deductible before you can receive benefits.

Willamette Dental plans also maintain fixed out-of-pocket costs. You and your family will never be surprised by any unknown costs for dental services.

Willamette Dental Plan	In-Network *ONLY*
Deductible	None
Benefit Maximum	None
General & Orthodontic Office Visit	$15 Copay
Preventive Care/Diagnostic	Office Visit Copay Applies
Topical Fluoride Application	
X-rays	
Fillings	
Sealants (per tooth)	
Local Anesthesia	
Oral Surgery (Simple Extractions)	
Periodontal Charting & Evaluation	
Endodontics & Periodontics	Varying Procedure Copay
Root Canal Therapy—Anterior, Bicuspid, Molar	
Osseous Surgery (per Quadrant)	
Bridges, Dentures, Crowns/Inlays/Onlays	
Nitrous Oxide	
Periodontal Root Planing	
Orthodontia	
Pre-Orthodontia Treatment	$150 Copay
Copay credited towards Comprehensive Ortho Treatment copay if patient accepts treatment plan	
Comprehensive Orthodontia Treatment	$2,800 Copay
Dental Implants	
Dental Implant Surgery	Implant benefit maximum of $1,500 per year

Frequency limitations may apply—see your dental booklet for additional information.

VISION

Bonner County offers vision insurance through United Heritage/Vision Service Plan. Bonner County pays the cost of employee coverage. You may choose to cover dependents through payroll deduction.

To find a participating eye care provider or to review your plan coverage before your appointment, visit www.vsp.com or call 800-877-7195.

VSP Choice Network Plan B	In-Network	Out-of-Network
Copays		
Well Vision Exam	$10 Copay	
Hardware	$25 Copay	
Exam		
Benefit	Copay Applies	Up to $45 Reimbursement
Frequency	12 Months	
Hardware—Lenses		
Single Vision	Copay Applies	Up to $30 Reimbursement
Lined Bifocal	Copay Applies	Up to $50 Reimbursement
Lined Trifocal	Copay Applies	Up to $65 Reimbursement
Frequency	12 Months	
Hardware—Frames*		
Benefit	$130 Allowance $70 Allowance (Costco)	Up to $70 Reimbursement
Frequency	24 Months	
Major Restorative		
Elective	$130 Allowance	Up to $105 Reimbursement
Frequency—in lieu of Lenses & Frames	12 Months	

*20% savings on the amount over your allowance

Allowance per service may vary based on VSP provider. Please see your vision summary for additional information.

GENERAL PURPOSE FLEXIBLE SPENDING ACCOUNTS

A General Purpose Flexible Spending Account (FSA) is an option with your employer's health care coverage and is only available to you if you are not enrolled on the Health Savings Account (HSA) plan.

GENERAL PURPOSE FSA RULES
Employees are not allowed to contribute to both an HSA as well as a General Purpose (non-limited) health FSA.

The main advantage of FSA funds is that employees can pay for qualified expenses tax-free while reducing their taxable income. The Bonner County FSA allows participants to carry over up to $500 in unused funds at the end of each plan year to reimburse expenses incurred in the next year. Any leftover funds above $500 will be forfeited. This carryover does not count towards your next year's annual contribution limits.

Dependent Care FSA Rules
Dependent Care FSA (DCAP) funds cover acre costs for your eligible dependents while you are at work. This excludes things such as, but not limited to, educational expenses and/or tuition, overnight camp, registration, or late payment fees and field trips.

There are contribution limits to FSAs. In 2022, contribution limits are:
Flexible Spending Account—$2,850
Dependent Daycare Flexible Spending Account—$5,000 maximum ($2,500 married filing separately)

Unfortunately, we cannot provide a definitive list of "qualified medical expenses." A determination of whether an expense is for "medical care" is based on all the relevant facts and circumstances. To be an expense for medical care, the expense has to be primarily for the prevention or alleviation of a physical or mental defect or illness.

Examples of Typical ELIGIBLE FSA Expenses:
- Dental Treatment (excluding whitening)
- Orthodontia
- Glasses and/or Contact Lenses
- Vision Correction Procedures
- Guide Dog or other service animal
- Acupuncture
- Nursing Services
- Prosthesis
- Transplants
- Drug & Alcohol Treatment
- Fertility Treatment
- Vasectomy

Examples of Typical INELGIBILE FSA Expenses:
- Insurance premiums
- Long Term Care premiums
- Electrolysis or hair removal
- Funeral Expenses
- Over-the-counter medicine
- Swimming Lessons
- Cosmetic Procedures

LIMITED PURPOSE FLEXIBLE SPENDING ACCOUNTS

A limited purpose FSA is similar to general purpose FSA—the difference being that there are fewer eligible expenses. Members with a Limited Purpose FSA may use their funds for dental & vision expenses only.

LIMITED PURPOSE FSA RULES
Employees are allowed to contribute to both an HSA as well as a limited purpose FSA. This allows you to maximize your savings & tax benefits.

The main advantage of FSA funds is that employees can pay for qualified expenses tax-free while reducing their taxable income. The Bonner County Limited Purpose FSA allows participants to carry over up to $500 in unused funds at the end of each plan year to reimburse expenses incurred in the next year. Any leftover funds above $500 will be forfeited. This carryover does not count towards your next year's annual contribution limits.

There are contribution limits to Limited Purpose FSAs. In 2022, contribution limits are:
Flexible Spending Account—$2,850
Dependent Daycare Flexible Spending Account—$5,000 maximum ($2,500 married filing separately)

Unfortunately, we cannot provide a definitive list of "qualified medical expenses." A determination of whether an expense is for "medical care" is based on all the relevant facts and circumstances. To be an expense for medical care, the expense has to be primarily for the prevention or alleviation of a physical or mental defect or illness.

Examples of Typical ELIGIBLE Limited Purpose FSA Expenses:

- Dental cleaning
- Dental fillings
- Dental crowns
- Orthodontia
- Contact Lenses
- Eyeglasses
- Refractions
- Vision Correction Procedures

Examples of Typical INELGIBILE Limited Purpose FSA Expenses:

- Insurance premiums
- Medical expenses (deductibles, coinsurance, copays)
- Alcohol & drug rehab expenses
- Prescriptions
- Over—the– counter medicines
- Medical Equipment
- Contraceptives
- Cosmetic Procedures
- Expenses reimbursed by an insurance provider or health plan

DISABILITY INSURANCE

Bonner County provides full-time employees with the opportunity to enroll in short and long term disability income benefits (STD and LTD). The cost of LTD is covered 100% by the County. However, STD is optional and the employee would pay 100% for this benefit. In the event that you become disabled from a non-work related injury or sickness, disability income benefits are provided as a source of income. You are not eligible to receive short-term disability benefits if you are receiving workers' compensation benefits.

HERE'S HOW THE DISABILITY PLANS WORK:
Before STD benefits begin, you may be eligible for paid time off benefits. Please refer to your employee handbook for details on the paid time off policy. The STD plan pays 60 percent of your weekly pre-disability earnings, up to a maximum of $1,000 per week. STD benefits begin on the 7th continuous calendar day of an eligible disability (injury or sickness) and are payable for up to 12 weeks.

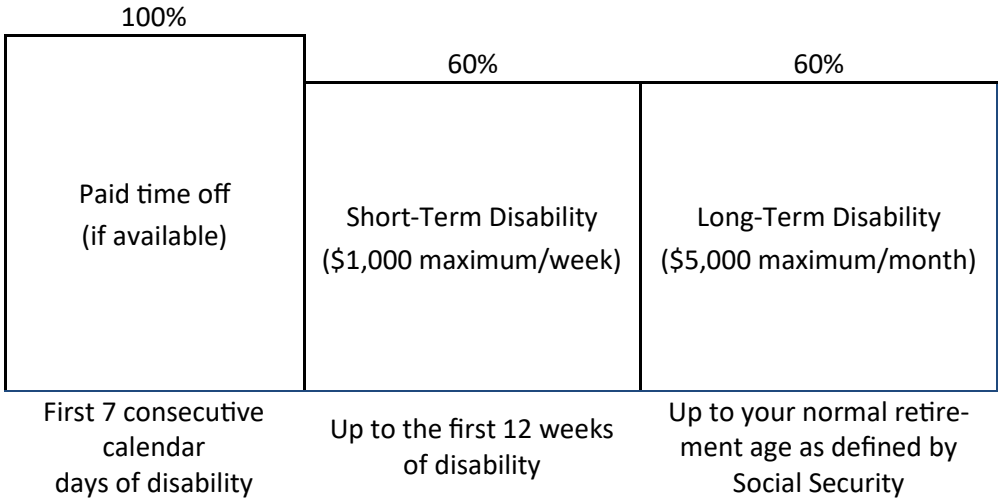
*This policy does include a **pre-existing clause** that states benefits will not be payable for any pre-existing Condition unless you've not received care for that condition for 180 consecutive days while insured under this policy or if you've been continuously insured under this policy for 365 consecutive days.*

To determine your cost to enroll in this benefit, please speak with the Bonner County Benefits Administration Team or view your information in the Employee Navigator Enrollment Portal.

The LTD plan pays 60 percent of your monthly pre-disability earnings, up to a maximum of $5,000 per month. LTD benefits begin the 90th day of continuous disability. The duration of payments is based on the insured's age when disability occurs. For a complete table of your benefit duration period, please refer to the Certificate of Coverage. Bonner County provides this benefit to you at no cost.

*This policy does include a **pre-existing clause** that states benefits will not be payable for any pre-existing condition unless you've not received care for that condition for 180 consecutive days while insured under this policy or if you've been continuously insured under this policy for 365 consecutive days.*

NOTE: Disability benefits can be reduced by "other income benefits." Please refer to the Reduction of Benefits – Other income section in your Certificate of Insurance.



LIFE INSURANCE

Bonner County pays the full cost of basic life insurance and accidental death and dismemberment (AD&D) for employees.

EMPLOYER PAID LIFE/AD&D INSURANCE

Employee life insurance amount is 1x your base annual earnings, up to a maximum of $100,000
Spouse life insurance is $1,000
Child(ren) life insurance (15 days up to 26 years*) is $1,000

Accidental Death & Dismemberment (AD&D) insurance is equal to your amount of life insurance. As you grow older, the amount of life and AD&D insurance for you will be reduced according to the following schedule:
Age 65 – the original amount of insurance will reduce to 65 percent
Age 70 – the original amount of insurance will reduce to 50 percent

VOLUNTARY LIFE/AD&D INSURANCE

Employees who want to supplement their group life insurance benefits may purchase additional coverage. When you enroll yourself and/or your dependents in this benefit you pay the full cost through semi-monthly payroll deductions. You can purchase:

BENEFIT AMOUNT(S)

	Guarantee Issue*	Amount of Insurance	Increments
Employee	$100,000	$10,000 - $250,000**	$10,000
Spouse	$25,000	$5,000 - $125,000***	$5,000
Children 15 days-6 mos	$10,000	$2,000—$10,000	$2,000

*The Guarantee Issue Amount for Your Spouse is 100% of your elected amount of life insurance or $25,000, whichever is less. The GI Amount for Your Dependent child(ren) is 100% of your elected amount of life insurance or $10,000, whichever is less.
**Not to exceed 3x basic annual earnings
***Not to exceed 50% of Employee's voluntary life amount

Conversion Privilege – An insured employee and dependent(s) may convert group voluntary life insurance coverage without Evidence of Insurability to an individual life insurance policy during the 31-day period following termination of employment.

Portability Privilege—An insured employee and dependent(s) may continue coverage when coverage would otherwise end by turning in a Portability application during the 31 day period following termination of employment.

Waiver of Premium – If an insured employee becomes totally disabled prior to attainment of age 60, if disability lasts nine months or more, no further premium will be required for the employee during continuance of total disability.

LIFE INSURANCE (CONTINUED)

VOLUNTARY LIFE / AD&D—TO CALCULATE YOUR PREMIUM, DO THE FOLLOWING:

_____ / 1,000 = _____ X _____ = _____
Amount of Coverage | Rate | Monthly Total

Employee & Spouse Rate Table	
Age	**Rates per $1,000**
0-24	$0.08
25-29	$0.07
30-34	$0.08
35-39	$0.11
40-44	$0.16
45-49	$0.25
50-54	$0.40
55-59	$0.64
60-64	$0.84
65-69	$1.32
70-74	$2.29
75+	$4.00

Child(ren) Unit Life/AD&D*
Rates per $1,000
$0.22

Follow the same method described above to select a benefit amount and calculate premiums for optional dependent spouse and/or child(ren) coverage. **Your spouse's rate is based on your age,** so find your age bracket in the far left column of the Employee & Spouse Premium Table.

*Regardless of how many children you have, they are included in the "All Children" premium amounts listed in the table.

Please note: You will only be able to apply for guaranteed issue life insurance when first eligible.

If you do not enroll, future elections will require health questions (Evidence of Insurability).

If an employee enrolls in an amount less than the guaranteed issue limit, they may increase by $10,000 each year in the future without health questions until the guarantee issue limit has been reached. This is the step-up guarantee which applies only to employees.

ACCIDENT - United Heritage

Bonner County offers additional voluntary benefits, including a Voluntary Accident & Voluntary Critical Illness plan. Accident & Critical Illness coverages offer financial protection for the unexpected and provide monetary payouts directly to you based on the type of claim you experience.

Accidents happen! If you enroll, this plan will pay you certain fixed dollar amounts for certain **on and off-the-job** accidents or injuries for which you obtain medical care—there are over 80 possible benefit payments available.

Accident Plan Schedule of Benefits (Condensed as an Example*)	Benefit Payment
Accidental Death	$30,000
Knee Dislocation	$1,800
Leg Fractures	$1,200
Hospital Admission	$1,000
Ground Ambulance	$300
Emergency Room Visit	$150

More Examples of Scheduled Benefits:

- Burns
- Lacerations
- X-Rays
- Urgent Care Visits
- Dental Crown Repairs due to accidental injury
- Stiches

Please see detailed summary for full list of scheduled benefit payouts.

If a family is selected, the spouse & child benefits equal 100% of the employee amount for most of the benefits!

- **Accidental Death amount is 50% of the employee amount for a spouse and 10% for the child.**
- **Children can be enrolled until age 26**

United Heritage Accident Premiums	
	Total Monthly Premium
Employee Only	$12.97
Employee + Spouse	$20.48
Employee + Child(ren)	$21.78
Employee + Family	$34.27

ACCIDENT - AFLAC—New in 2022!

Bonner County offers additional voluntary benefits, including a Voluntary Accident & Voluntary Critical Illness plan. Accident & Critical Illness coverages offer financial protection for the unexpected and provide monetary payouts directly to you based on the type of claim you experience.

The Aflac Accident plan provides cash benefits directly to you to help with out-of-pocket expenses: medical and nonmedical associated with treatment in the event of a covered accident either **on or off-the-job**. A sudden accident might stop you in your tracks, but your bills like mortgages, utilities, groceries, and out-of-pocket costs will keep on coming. Accident insurance can help cover the costs associated with the treatment of a covered accidental injury. More importantly, the plan helps you focus on getting better, not worrying about how you will pay your bill.

Accident Plan Schedule of Benefits (Condensed as an Example*)	Benefit Payment
Accidental Death	$30,000
Knee Dislocation	$1,800
Leg Fractures	$1,200
Hospital Admission	$1,000
Ground Ambulance	$300
Emergency Room Visit	$150

More Examples of Scheduled Benefits:

- Burns
- Lacerations
- X-Rays
- Urgent Care Visits
- Dental Crown Repairs due to accidental injury
- Stiches

****Please see detailed summary for full list of scheduled benefit payouts.***

If a family is selected, the spouse & child benefits equal 100% of the employee amount for most of the benefits!

- **Accidental Death amount is 50% of the employee amount for a spouse and 10% for the child.**
- **Children can be enrolled until age 26**

AFLAC Accident Premiums	
	Total Monthly Premium
Employee Only	$11.47
Employee + Spouse	$19.97
Employee + Child(ren)	$26.48
Employee + Family	$34.98

CRITICAL ILLNESS - United Heritage

Critical Illness Plan Schedule of Benefits (Condensed as an Example*)	Benefit Payment
Elected Benefit Amount	$5,000 Minimum / $50,000 Maximum ($5,000 increments)
Guarantee Issue	$20,000
First Occurrence Payments (allowed in each category)	100% of elected benefit amount
Recurrence Payments (allowed once)	50% of First Occurrence
Lifetime Maximum Benefit Payout	300% of elected benefit amount
Wellness Benefit Rider	Pays $25 Annually for Employee and/or Spouse
Hospital Confinement Rider	Pays $50 per day for hospital confinement

Once a First & Second occurrence have occurred in a single category, that category is then closed for future benefit payouts.

Please see detailed summary for full list of scheduled benefit payouts.

Critical Illness Monthly Rates per $1,000 of Benefit

Hospital Confinement Rider Monthly Age Rates

Attained Age	Employee (Children Included)		Employee & Family (Children & Spouse)		Employee (Children Included)		Employee & Family (Children & Spouse)	
	Non-Smoker	Smoker	Non-Smoker	Smoker	Non-Smoker	Smoker	Non-Smoker	Smoker
Under 40	$0.51	$0.80	$0.74	$1.09	$0.24	$0.37	$0.49	$0.70
40—44	$0.88	$1.57	$1.32	$2.15	$0.37	$0.65	$.0.78	$1.18
45—49	$1.32	$2.63	$2.05	$3.58	$0.53	$1.02	$1.14	$1.82
50—54	$1.92	$4.24	$3.07	$5.74	$0.76	$1.64	$1.69	$2.86
55—59	$2.78	$6.74	$4.55	$9.06	$1.08	$2.54	$2.47	$4.37
60—64	$4.01	$10.52	$6.72	$14.05	$1.53	$3.90	$3.59	$6.59
65—69	$5.60	$15.56	$9.54	$20.71	$1.88	$5.06	$4.49	$8.47
70—74	$8.01	$21.36	$13.57	$28.63	$2.68	$6.89	$6.36	$11.7
75—79	$11.03	$26.31	$18.29	$35.79	$3.51	$8.09	$8.02	$13.99

Wellness Benefit Rider Rate Per Month	
Employee	Employee & Family
$1.20	$2.39

CRITICAL ILLNESS—TO CALCULATE YOUR PREMIUM, DO THE FOLLOWING:

_____ @ (_____ / $1,000 X _____) + _____ + _____ = _____

Employee Age | *Critical Illness Benefit Amount* | *Critical Illness Rate* | *Hospital Rate (Required)* | *Wellness Rate (Required)* | *Monthly Total*

Critical Illness Rates are based on Employee's Age & Employee's tobacco use status. Children are automatically covered when an employee enrolls in this coverage.

CRITICAL ILLNESS & CANCER - AFLAC

Critical Illness Plan Schedule of Benefits (Condensed as an Example*)	Benefit Payment
Elected Benefit Amount	$10,000 Minimum / $100,000 Maximum ($5,000 increments)
Guarantee Issue	$10,000
First Occurrence Payments (allowed in each category)	100% of elected benefit amount
Recurrence Payments (allowed once)	50% of First Occurrence
Wellness Benefit Rider	Pays $50 Annually for Employee and/or Spouse
Cancer (internal or Invasive)	100% of elected benefit amount
Skin Cancer	$1,000 per calendar year
Metastatic Cancer	25% of elected benefit amount

****Please see detailed summary for full list of scheduled benefit payouts.***

Critical Illness & Cancer Benefit Monthly Rates per $1,000 of Benefit			Hospital Policy Monthly Rates—$10,000	
Attained Age	**Employee (Children Included)**	**Spouse**	**Tier**	**Monthly Premium**
	Non-Smoker	**Non-Smoker**	**Employee Only**	$20.10
18—24	$0.72	$1.18	**Employee & Spouse**	$40.48
25—29	$0.87	$1.39	**Employee & Child(ren)**	$32.20
30—34	$1.16	$1.79	**Employee & Family**	$52.58
35—39	$1.55	$2.34	***Hospital Admission***: For sickness or covered accident, pays $1,000 per admission. **Hospital Confinement**: Pays $150 per day; 31 days per sickness or covered accident. ***Intensive Care***—Pays $150 per day up to 10 days per confinement per covered sickness or covered accident. **Intermediate Intensive Care**—Pays $75 per day up to 10 days per covered sickness or covered accident.	
40—44	$2.03	$3.03		
45—49	$2.50	$3.82		
50—54	$3.02	$4.76		
55—59	$3.56	$5.69		
60—64	$4.24	$6.89		

CRITICAL ILLNESS—TO CALCULATE YOUR PREMIUM, DO THE FOLLOWING:

_____ @ (_____ / $1,000 X _____) + _____ + _____ = _____

Employee Age | *Critical Illness Benefit Amount* | *Critical Illness Rate* | *Hospital Rate (Required)* | *Wellness Rate (Required)* | *Monthly Total*

Critical Illness Rates are based on Employee's Age & Employee's tobacco use status. Children are automatically covered when an employee enrolls in this coverage.

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EAP & Work-Life Services

An Overview for Employees

Life presents us with challenges at work and at home on a daily basis. You do not have to face these challenges alone, even if you're far away.

We Are Here to Help

EAP benefits are available to all employees and their families at NO COST to you. The EAP offers confidential advice, support, and practical solutions to real-life issues. You can access these confidential services by calling the toll-free number and speaking with our care team, or accessing online.

EAP Services for Employees & Families

Confidential Counseling
Up to 6 face-to-face, video or telephonic counseling sessions for relationship and family issues, stress, anxiety, and other common challenges.

24-hour Crisis Help
Toll-free access for you or a family member experiencing a crisis.

Online Peer Support Groups
Online support groups for addiction recovery, anxiety, depression, frontline workers, grief and loss, parenting, and more.

Tess, AI Chat-bot
24/7 chatbot for emotional support and check-ins to boost wellness.

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Your EAP provides a wide range of work-life services to help you manage a variety of challenges

Financial Help
30-days of access with a personal money coach who will work with the member toward financial wellness by identifying financial goals, assessing current financial situation, and providing a suggested detailed action plan.

Legal Services
One 30-minute legal consultation per each separate legal matter at no cost, 25% reduction from the normal hourly rate if member retains attorney or mediator.

Online Legal Forms
Create, save, print, and revise online legal forms including wills, contracts, leases, and many more.

Child & Parenting Services
Get information and support on parenting, school issues, adoption, daycare, and other important issues for parents.

Adult & Eldercare Services
Get assistance in finding quality information and services including transportation, meals, activities, daytime care, housing, and more.

Webinars & Trainings
Industry experts will present monthly work-life webinars on a variety of topics.

EAP Services & Support for Supervisors

Managing people can be challenging. All supervisors have fast access to phone consultations and trainings about the EAP and management topics:

- Critical incidents
- Drug-free workplace
- Making employee referrals
- Organizational development
- Education and training
- Conflicts in the workplace

We Are Here to Help

Phone: 866.750.1327

Website: uprisehealth.com/members

Access Code: bonnercounty

Welcome to your 2022–2023 Wellness Program! All medically enrolled employees will have opportunities to participate in various wellness activities to earn an incentive. Your new program details are outlined in this guide.

STEPS TO EARN AN INCENTIVE

STEP 1: BIOMETRICS WITH LAB WORK

DEADLINE: JULY 31, 2023

You must complete at least **one (1)** of the options below to earn credit for this requirement.

- Visit your Primary Care Physician (PCP) for annual lab work. Print out the **Physician Results Form** located on the **Wellness Portal** within the **Wellness Locker** and take it to your appointment to be completed by your PCP. All metrics must be collected in order to fulfill this requirement.
- Visit **White Cross Pharmacy** at **(208) 263 9080** to complete your **Biometric Screening** and fulfill this requirement.
- Attend an **Onsite Biometric Screening** at Bonner County. Details will be announced via email at a later date.

STEP 2: ANNUAL WELLNESS VISIT WITH PRIMARY CARE PROVIDER

DEADLINE: JULY 31, 2023

Visit your Primary Care Physician (PCP) to complete your annual physical. Print out the **Proof of Annual Visit Form** located on the **Wellness Portal** within the **Wellness Locker** and take it to your appointment to be signed by your PCP.

Please Note: If you complete the lab work with your physician at the same time you receive your **Annual Wellness Visit**, you do not need to submit the **Proof of Annual Visit Form**. The **Physician Results Form** will count for this requirement as well as count for **Step 1** above. If you attend an **onsite screening** or go to **White Cross Pharmacy**, **you will need to submit the Proof of Annual Visit Form** to fulfill this requirement.

STEP 3: KNOW YOUR NUMBER ASSESSMENT

DEADLINE: JULY 31, 2023

Upon logging into the Wellness Portal or mobile app, you will be prompted to complete the **Know Your Number (KYN) Assessment.** Complete all questions, *except* for the **Health Metrics** section. Wellworks will upload your screening results once you complete **Step 1**.

- If your health metrics have already been entered, complete the questionnaire, and click **Finish** to submit your responses.
- If your health metrics have not been entered, complete the questionnaire, and click **SAVE**. The assessment will be completed once your metrics are entered by Wellworks For You.

Once your assessment is completed in its entirety (questionnaire and health metrics), your results report will be generated and available on the **Know Your Number Assessment** page, as well as uploaded to the **Wellness Locker** under the **Health Records** section. Your participation in the assessment will also be updated at this time.

STEP 4: TOBACCO ATTESTATION FORM/CESSATION E-LEARNING SERIES

DEADLINE: JULY 31, 2023

Complete the **Tobacco Attestation Form** and **Tobacco Cessation Program**, if applicable, to receive credit for this step. Whether or not a tobacco user, you must complete and sign the **Tobacco Attestation Form** to certify that you are tobacco-free or a tobacco user.

- **Non-Tobacco Users:** If you certify that you do not use tobacco, you will fulfill this step by completing and submitting the **Tobacco Attestation Form** located on the Wellness Portal within the **Wellness Locker** linked on the homepage or via the menu page.
- **Tobacco Users:** If you certify that you use tobacco, you must complete the **six (6) week Tobacco Cessation e-Learning Series** on the Wellness Portal by **July 31, 2023** to complete this step.

TOBACCO CESSATION E-LEARNING SERIES:

1. Log into your Wellness Portal
2. Select the **e-Learning** section from the homepage
3. Select the **e-LS: Tobacco Cessation** from the e-Learning dashboard
4. Complete the **Pre-Module Survey**
5. Beginning with **Module 1**, you must watch each video and take the quiz associated with each module. If you do not pass the quiz (a 70% score or higher) you must wait 24 hours before taking the quiz again.
6. You will be required to wait **one (1) week** in between each module before the next module will open
7. After you finish **Module 6**, you must complete and submit the **Post-Module Survey**

PLEASE NOTE: The Tobacco Cessation program (including all quizzes and surveys) must be completed by **July 31, 2023.** To ensure that you complete the entire program prior to the deadline, you must begin the program by **June 5, 2023.**

ADDITIONAL RESOURCES

View a variety of educational e- Learning Series under the **e-Learning** section of the homepage. Begin by completing the **Pre-Module Survey** then watching the first video. Watch each week's video and complete the corresponding quiz. After successfully completing each quiz, you can proceed to the next module. If you do not pass the quiz (a 70% score or higher) you must wait 24 hours before taking the quiz again. After you finish the final module, you will complete and submit the **Post-Module Survey**.

e-Learning Series Topics:

- **Wellworks For You and Trinity Advisors Group Financial Wellness**
- **Healthy Living with a Chronic Condition**
- **Stress Management**
- **Healthy Habits for Healthy Families**
- **Physical Activity**

INCENTIVES

You must complete **Steps 1-4** to be eligible for a **Premium Reduction and HRA/HSA incentive**. Premium Reduction incentives will be distributed on the **first of the month following 30 days of completion**. HRA/HSA contributions will be completed on a **quarterly basis** (August-October; November-January; February-April; May-July).

MEDICAL ENROLLMENT STATUS	INCENTIVE
Enrolled in HSA Plan	$300.00 Contribution
Enrolled in HRA Plan	$300.00 Contribution

WELLNESS PORTAL

In order for your participation in the program to be tracked, employees must be registered under the **Bonner County** Portal. If you do not have an account, please follow the instructions below.

In accordance with HIPAA confidentiality laws, your individual data is accessible only to you and the third-party vendor, Wellworks For You.

NEW USERS: REGISTER ON THE WELLNESS PORTAL

1. Go to **www.wellworksforyoulogin.com**
2. Click **Register** to create an account as a **New Member**
3. Enter your Company ID: **10925**
4. Select **YES** to confirm the company name is correct
5. Complete the registration process

FORGOT YOUR USERNAME OR PASSWORD?

1. Go to **www.wellworksforyoulogin.com**
2. Click the link **Forgot Username** or **Forgot Password**
3. Follow the instructions to retrieve your username or reset your password
4. If issues persist, please contact **Wellworks For You** at **800.425.4657**

ADDITIONAL INFORMATION

SMARTPHONE APP

The Wellworks For You Portal App includes all your favorite features from the Portal including programs and events listings, incentive tracking, and more! Simply search for **Wellworks For You** in the Play Store or App Store to download the free App.

NOTIFICATIONS INBOX

View your wellness program messages in the **Notifications Inbox.** Click on the notification bell at the top right of the portal header and mobile app homepage to view text-only, video, and/or image messages in full detail.

VIEW YOUR INCENTIVE PROGRESS

Looking for an overview of your progress to date?

1. Log into your Wellness Portal (**www.wellworksforyoulogin.com**)
2. View your program status right on the homepage in the top right-hand section
    - **My Progress** will show completion of required program components
3. For more details, click on any title in the "My Next Steps" section**.** Selecting an event title will open a pop-up detailed information.
4. Once a component is complete, there will be a check mark next to the event title on the homepage.

WELLNESS LOCKER

All forms are located in your wellness portal and mobile app within the **Wellness Locker.** To access, log into your wellness portal or mobile app and select **Wellness Locker** from the menu. Download and/or print PDF forms for completion.

SUBMIT YOUR COMPLETED DOCUMENTS BY JULY 31, 2023

All completed documents should be submitted to the **Wellworks Forms Department** in **one (1)** of the following ways:

- Upload to Portal: Click the **Upload a Form** from the homepage or via the menu page. Select the event title from the dropdown and upload your form to the portal. This will be securely emailed for processing. Users are limited to **one (1)** file per email.
- Upload to Mobile App: Take a photo of your form using your Smartphone. Next, upload it to the **Wellworks For You Mobile App** via the **Contact Us/Send** a Form tab in the menu, located in the top left corner of the home screen.

REQUIRED NOTICES

HIPAA NOTICE OF PRIVACY PRACTICES

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH Act) place important restrictions on sharing your medical information and provide you with important privacy rights. This Notice of Privacy Practices (the "Notice") replaces all prior notices provided by the Plan Sponsor and is effective on the Date Distributed noted above. This Notice describes the legal obligations of the Plan Sponsor and your legal rights regarding your "protected health information" ("PHI") held by your Plan Sponsor and Group Health Plan. This Notice describes how your PHI may be used or disclosed to carry out treatment, payment, or health care operations, or other purposes permitted by law.

Generally, PHI includes your personal information collected from you or created by your Group Health Plan, or the Plan Sponsor on behalf of a Group Health Plan, that relates to your past, present, or future physical or mental health or condition; the provision of health care; or the past, present, or future payment for the provision of health care, and includes your elections to enroll in the Plan. If you have any questions about this Notice or about our privacy practices, please contact your Privacy Officer identified below.

The Plan Sponsor may retain agents, service providers and third party administrators to administer all or part of your Group Health Plan such as claims payment and enrollment management. The term Plan Sponsor as used in this Notice includes all entities that provide services related to your Group Health Plan that have access to your PHI. The Plan Sponsor and contracted service providers are required by law to follow the terms of this Notice.

The Plan Sponsor is required by law to maintain the privacy of your PHI, provide you with certain rights with respect to your PHI, provide you with a copy of this Notice, and follow the terms of this Notice. The Plan Sponsor reserves the right to change the terms of this Notice and its practices regarding your PHI. If there is any material change to this Notice, the Plan Sponsor will provide you with a copy of the revised Notice of Privacy Practices.

Use and Disclosure

The Plan Sponsor may use or disclose your PHI under certain circumstances without your permission. All of these certain circumstances will fall within one of the categories listed below.

- **For Treatment,** to facilitate medical treatment or services by providers including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you.
- **For Payment** to determine your eligibility for Plan benefits, to facilitate payment for the treatment or services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage.
- **For Health Care Operations**, uses and disclosures necessary to run the Plan.
- **Treatment Alternatives or Health-Related Benefits and Services** that might be of interest to you.
- **To Business Associates** to perform various functions on our behalf or to provide certain types of services. A Business Associates will receive, create, maintain, transmit, use, and/or disclose your PHI, but only after they agree in writing with the Plan Sponsor to implement appropriate safeguards regarding your PHI.
- **As Required by Law** when required to do so by federal, state, or local law.
- **To Avert a Serious Threat to Health or Safety** to you, or the health and safety of the public, or another person, limited to someone able to help prevent the threat.

In addition, the following categories describe other ways that the Plan Sponsor may use and disclose your PHI without your specific authorization. All of the ways the Plan Sponsor is permitted to use and disclose information will fall within one of the categories.

- **Organ and Tissue Donation**, after your death to an organization that handles organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.
- **Military**, if you are a member of the armed forces, as required by military command authorities. The Plan Sponsor may also release PHI about foreign military personnel to the appropriate foreign military authority.
- **Workers' Compensation** or similar programs, but only as authorized by, and to the extent necessary to comply with, laws relating to workers' compensation and similar programs that provide benefits for work-related injuries or illness.
- **Public Health Risks** for public health activities. These activities generally include the following:
- to prevent or control disease, injury, or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if the Plan Sponsor believes that a patient has been the victim of abuse, neglect, or domestic violence. The Plan Sponsor will only make this disclosure if you agree, or when required or authorized by law.
- **Health Oversight Activities** for activities authorized by law. For example, audits, investigations, inspections, and licensure.
- **Lawsuits and Disputes** in response to a court or administrative order, including a response to a lawful subpoena, discovery request, or other process by someone involved in a legal dispute, but only if efforts have been made to tell you about the request or to obtain a court or administrative order protecting the information requested.

Law Enforcement if asked to do so by a law-enforcement official—

- in response to a court order, subpoena, warrant, summons, or similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if, under certain limited circumstances, the Plan Sponsor is unable to obtain the victim's agreement;
- about a death that the Plan Sponsor believes may be the result of criminal conduct; and
- about criminal conduct.
- **Coroners, Medical Examiners, and Funeral Directors**, for example, to identify a deceased person or determine the cause of death. The Plan Sponsor may also release medical information about patients to funeral directors, as necessary to carry out their duties.
- **National Security and Intelligence Activities** to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.
- **Inmates** of a correctional institution or in the custody of a law-enforcement official, to the correctional institution or law-enforcement official if necessary for the institution to provide you with health care; to protect your health and safety or the health and safety of others; or for the safety and security of the correctional institution.
- **Research**, to researchers when the individual identifiers have been removed; or when an institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of the requested information, and approves the research.

Required Disclosures
The Plan Sponsor is required to disclose your PHI to:
Government Audits to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule.
Disclosures to You on your request, the portion of your PHI that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits.

Other Disclosures
The Plan Sponsor may disclose your PHI to:
Personal Representatives authorized by you, or to an individual designated as your personal representative, or attorney-in-fact. You must provide a written notice/authorization and supporting documents such as a power of attorney. The Plan Sponsor does not have to disclose information to a personal representative if the Plan Sponsor has a reasonable belief that you have been, or may be, subjected to domestic violence, abuse, or neglect by such person; or treating such person as your personal representative could endanger you; or in the exercise of professional judgment, it is not in your best interest to treat the person as your personal representative.
Comply with your Authorization. Other uses or disclosures of your PHI not described above will only be made with your written authorization. The Plan Sponsor may deny a request to disclose your psychiatric notes. The Plan Sponsor will not use or disclose your PHI for marketing; or sell your PHI, unless you provide written authorization. You may revoke written authorizations at any time, so long as the revocation is in writing. Once the Plan Sponsor receives your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation.

Privacy Rights
Right to Inspect and Copy. You have the right to inspect and copy certain PHI that may be used to make decisions about your Plan benefits. If the information you request is maintained electronically, and you request an electronic copy, the Plan Sponsor will provide a copy in the electronic form and format you request, if the information can be readily produced in that form and format; if the information cannot be readily produced in that form and format, the Plan Sponsor will work with you to come to an agreement on form and format or provide you with a paper copy. To inspect and copy your PHI, you must submit your request in writing to the Privacy Officer identified below. The Plan Sponsor may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request. The Plan Sponsor may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may request that the denial be reviewed by submitting a written request to the Privacy Officer identified below.
Right to Amend. If you feel that your PHI is incorrect or incomplete, you may ask the Plan Sponsor to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan. To request an amendment, your request must be made in writing and submitted to the Privacy Officer identified below. In addition, you must provide a reason that supports your request. The Plan Sponsor may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, the Plan Sponsor may deny your request if it:
- is not part of the medical information kept by or for the Plan;
- was not created by the Plan, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the information that you would be permitted to inspect and copy; or
- is already accurate and complete.

If your request is denied, you have the right to file a statement of disagreement with the Plan Sponsor and any future disclosures of the disputed information will include your statement.

- **Right to an Accounting of Disclosures.** You have the right to request an "accounting" of certain disclosures of your PHI. The accounting will not include (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures. To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer identified below. Your request must state the time period you want the accounting to cover, which may not be longer than six years before the date of the request. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be provided free of charge. For additional lists, the Plan Sponsor may charge you for the costs of providing the list. The Plan Sponsor will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.
- **Right to Request Restrictions or limitation on your PHI** that the Plan Sponsor uses or discloses for treatment, payment, or health care operations. You also have the right to request a limit on your PHI that is disclosed to someone who is involved in your care or the payment for your care, such as a family member or friend. Except as provided in the next paragraph, the Plan Sponsor is not required to agree to your request. However, the Plan Sponsor will comply with any restriction request if (1) except as otherwise required by law, the disclosure is to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment); and (2) the PHI pertains solely to a health care item or service for which the health care provider involved has been paid in full by you or another person. To request restrictions, you must make your request in writing to the Privacy Officer identified below. In your request, you must state (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply—for example, disclosures to your spouse. If the Plan Sponsor honors the request, it will stay in place until you revoke it or the Plan Sponsor notifies you.
- **Right to Request Confidential Communications** about medical matters in a certain way or at a certain location. For example, you can ask that the Plan Sponsor only contact you at work or by mail. Your request must be made in writing to the Privacy Officer identified below and specify how or where you wish to be contacted. The Plan Sponsor will accommodate all reasonable requests.
- **Right to Be Notified of a Breach** in the event that the Plan Sponsor (or a Business Associate) discover a breach of unsecured PHI.
- **Right to a Paper Copy of This Notice.** You may request a paper copy of this notice at any time from the Privacy Officer identified below, even if you have agreed to receive this notice electronically

Complaints

If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. To file a complaint with the Plan, contact:

BONNER COUNTY
Privacy Officer
1500 Highway 2, Suite 306
Sandpoint, ID 83684
208-265-1456

All complaints must be submitted in writing. You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office for Civil Rights or with us.

NEWBORNS' AND MOTHER'S HEALTH PROTECTION ACT

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

WOMEN'S HEALTH AND CANCER RIGHTS ACT

Enrollment Notice

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply: Please see plan SBCs for deductible/coinsurance amounts. If you would like more information on WHCRA benefits, contact your HR administrator.

WHAT IS COBRA CONTINUATION COVERAGE?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

Please speak with your HR Contact or Pacific Source Administrators for more information on your COBRA Rights and Qualifying Events.

HIPAA SPECIAL ENROLLMENT NOTICE

This notice is being provided to ensure that you understand your right to apply for group health insurance coverage. You should read this notice even if you plan to waive coverage at this time.

Loss of Other Coverage

If you are declining coverage for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).
Example: You waived coverage because you were covered under a plan offered by your spouse's employer. Your spouse terminates his employment. If you notify your employer within 30 days of the date coverage ends, you and your eligible dependents may apply for coverage under our health plan.

Marriage, Birth or Adoption

If you have a new dependent as a result of a marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth or placement for adoption.
Example: When you were hired by us, you were single and chose not to elect health insurance benefits. One year later, you marry. You and your eligible dependents are entitled to enroll in this group health plan. However, you must apply within 30 days from the date of your marriage.

Medicaid or CHIP

If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.
Example: When you were hired by us, your children received health coverage under CHIP and you did not enroll them in our health plan. Because of changes in your income, your children are no longer eligible for CHIP coverage. You may enroll them in this group health plan if you apply within 60 days of the date of their loss of CHIP coverage.

For More Information or Assistance

To request special enrollment or obtain more information, please contact HR.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2022. Contact your State for more information on eligibility –

ALABAMA-Medicaid	CALIFORNIA-Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
ALASKA-Medicaid	**COLORADO-Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ARKANSAS-Medicaid	**FLORIDA-Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA-Medicaid	MAINE-Medicaid
A HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: (678) 564-1162, Press 2	Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711
INDIANA-Medicaid	**MASSACHUSETTS-Medicaid and CHIP**
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840
IOWA-Medicaid and CHIP (Hawki)	**MINNESOTA-Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739
KANSAS-Medicaid	**MISSOURI-Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
KENTUCKY-Medicaid	**MONTANA-Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
LOUISIANA-Medicaid	**NEBRASKA-Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA-Medicaid	SOUTH CAROLINA-Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
NEW HAMPSHIRE-Medicaid	**SOUTH DAKOTA-Medicaid**
Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW JERSEY-Medicaid and CHIP	**TEXAS-Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NEW YORK-Medicaid	**UTAH-Medicaid and CHIP**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH CAROLINA-Medicaid	**VERMONT-Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
NORTH DAKOTA-Medicaid	**VIRGINIA-Medicaid and CHIP**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
OKLAHOMA-Medicaid and CHIP	**WASHINGTON-Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
OREGON-Medicaid	**WEST VIRGINIA-Medicaid and CHIP**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
PENNSYLVANIA-Medicaid	**WISCONSIN-Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
RHODE ISLAND-Medicaid and CHIP	**WYOMING-Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2022, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2023)

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, please contact the PacificSource customer service team at 1-888-246-1370. 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 at www.dol.gov/ebsa/healthreform or call 1-888-246-1370 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	All providers: $1,500 individual/$3,000 family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible
Are there services covered before you meet your deductible?	Yes. In-network: preventive care; office visits; Urgent care. Prescription drug coverage for Tier 1 drugs.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. $250 prescription drug deductible	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.
What is the out-of-pocket limit for this plan?	All providers: $6,250 individual/$12,500 family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing 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.
Will you pay less if you use a network provider?	Yes. See http://providerdirectory.PacificSource.com/?nPlan=Voyager or call 1-888-246-1370 for a list of network providers. Please refer to your member id card for the name of your network.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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
		In-Network Providers (You will pay the least)	Out-of-Network Providers (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	$30 copayment/visit, deductible does not apply.	Deductible then 40% coinsurance	Copayment applies to in-network office visit only. Other office or clinic services, deductible then 20% coinsurance. Telemedicine In-network: $0 copayment/visit, deductible does not apply.
	Specialist visit	$45 copayment/visit, deductible does not apply.		
	Preventive care/screening/ immunization	No charge, deductible does not apply		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 provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Deductible then 20% coinsurance	Deductible then 40% coinsurance	None
	Imaging (CT/PET scans, MRIs)			Preauthorization is required.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **http://PacificSource.com/drug-list/PDL/.**	Tier one drugs	Retail: 30 day supply: $15 copayment/prescription, deductible does not apply 60 day supply: $30 copayment/prescription, deductible does not apply 90 day supply: $45 copayment/prescription, deductible does not apply Mail: $45 copayment/prescription, deductible does not apply		Prescription benefit includes certain outpatient drugs as a preventive benefit at no charge, deductible does not apply. Retail and mail are limited to a 90 day supply. Preauthorization is required for certain drugs. Specialty drugs are limited to 30 day supply.
	Tier two drugs	Retail: 30 day supply: Deductible then $30 copayment/prescription 60 day supply: Deductible then $60 copayment/prescription 90 day supply: Deductible then $90 copayment/prescription Mail: Deductible then $90 copayment/prescription		
	Tier three drugs	Retail: 30 day supply: Deductible then $45 copayment/prescription 60 day supply: Deductible then $90 copayment/prescription 90 day supply: Deductible then $135 copayment/prescription Mail: Deductible then $135 copayment/prescription		
	Specialty drugs	Deductible then $200 copayment/prescription		

If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory surgery center: Deductible then 10% coinsurance Other facilities: Deductible then 20% coinsurance	Deductible then 40% coinsurance	None
	Physician/surgeon fees			
If you need immediate medical attention	Emergency room care	Deductible then $100 copayment/visit, plus 20% coinsurance		Copayment waived if admitted.
	Emergency medical transportation	Deductible then 20% coinsurance		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.
	Urgent care	$30 copayment/visit, plus 20% coinsurance, deductible does not apply.	Deductible then 40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible then 20% coinsurance	Deductible then 40% coinsurance	Limited to semi-private room unless intensive or coronary care units, medically necessary isolation, or hospital only has private rooms. Preauthorization is required for some inpatient services.
	Physician/surgeon fees			None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Outpatient therapy visits: $30 copayment/visit, deductible does not apply Other outpatient services: Deductible then 20% coinsurance	Deductible then 40% coinsurance	None
	Inpatient services	Deductible then 20% coinsurance		Preauthorization is required for some inpatient services.

If you are pregnant	Office visits	Deductible then 20% coinsurance	Deductible then 40% coinsurance	Cost sharing 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. This benefit only covers the enrolled employee and the enrolled spouse. Maternity coverage for dependent children is only covered if there is a complication.
	Childbirth/delivery professional services			
	Childbirth/delivery facility services			
If you need help recovering or have other special health needs	Home health care	Deductible then 20% coinsurance	Deductible then 40% coinsurance	Limited to 130 visits/year. No coverage for private duty nursing or custodial care.
	Rehabilitation services			Inpatient: Preauthorization is required. Covered up to 30 days/year. Outpatient: Covered up to 30 visits/year. No coverage for recreation therapy.
	Habilitation services			Inpatient: Preauthorization is required. Covered up to 30 days/year. Outpatient: Covered up to 30 visits/year. No coverage for recreation therapy.
	Skilled nursing care			Limited to 60 days/year. No coverage for custodial care.
	Durable medical equipment			Limited to: one pair/year for glasses or contact lenses; one breast pump/pregnancy; $150/year for wig for chemotherapy or radiation therapy. Preauthorization is required if equipment is over $1,000 and for power-assisted wheelchairs.
	Hospice services	No charge, deductible does not apply		No coverage for private duty nursing.

If your child needs dental or eye care	Children's eye exam	Not covered
	Children's glasses	
	Children's dental check-up	

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 to save the life of the mother)
- Bariatric surgery
- Cosmetic surgery
- Custodial care
- Dental care (Adult)
- Dental check-up (Child)
- Hearing aids (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care, other than with diabetes mellitus
- Weight loss programs

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

- Acupuncture
- Chiropractic care
- Hearing aids (Child)

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 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 1-888-246-1370 or the Idaho Department of Insurance at 1-800-721-3272 or at doi.idaho.gov.

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 1-866-281-1464.

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	$1,500
Specialist copayment	$45
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$10
Coinsurance	$2,200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,770**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$1,500
Specialist copayment	$45
Hospital (facility) coinsurance	20%
Other copayment	$30

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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,200
Copayments	$800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,020**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$1,500
Specialist copayment	$45
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$200
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,900**

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

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, please contact the PacificSource customer service team at 1-888-246-1370. 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 at www.dol.gov/ebsa/healthreform or call 1-888-246-1370 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	All providers: $2,000 individual	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	All providers: $5,000 individual	The out-of-pocket limit is the most you could pay in a year for covered services.
What is not included in the out-of-pocket limit?	Premiums, balance-billing 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.
Will you pay less if you use a network provider?	Yes. See http://providerdirectory.PacificSource.com/?nPlan=Voyager or call 1-888-246-1370 for a list of network providers. Please refer to your member id card for the name of your network.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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
		In-Network Providers (You will pay the least)	Out-of-Network Providers (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	Deductible then 20% coinsurance	Deductible then 40% coinsurance	None
	Specialist visit			
	Preventive care/screening/ immunization	No charge, deductible does not apply	40% coinsurance, deductible does not apply	Preventive Physicals: annually. Well Woman Visits: annually. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Deductible then 20% coinsurance	Deductible then 40% coinsurance	None
	Imaging (CT/PET scans, MRIs)			Preauthorization is required.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **http://PacificSource.com/drug-list/PDL/**	Tier one drugs	Retail and Mail: Deductible then 20% coinsurance		Prescription benefit includes certain outpatient drugs as a preventive benefit at no charge, deductible does not apply. Retail and mail are limited to a 90 day supply. Preauthorization is required for certain drugs. Specialty drugs are limited to 30 day supply.
	Tier two drugs			
	Tier three drugs			
	Specialty drugs	Deductible then $200 copayment/prescription		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory surgery center: Deductible then 10% coinsurance Other facilities: Deductible then 20% coinsurance	Deductible then 40% coinsurance	None
	Physician/surgeon fees			

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
		In-Network Providers (You will pay the least)	Out-of-Network Providers (You will pay the most)	
If you need immediate medical attention	Emergency room care	Deductible then 20% coinsurance		None.
	Emergency medical transportation			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.
	Urgent care	Deductible then 20% coinsurance	Deductible then 40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible then 20% coinsurance	Deductible then 40% coinsurance	Limited to semi-private room unless intensive or coronary care units, medically necessary isolation, or hospital only has private rooms. Preauthorization is required for some inpatient services.
	Physician/surgeon fees			None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Deductible then 20% coinsurance	Deductible then 40% coinsurance	None
	Inpatient services			Preauthorization is required for some inpatient services.
If you are pregnant	Office visits	Deductible then 20% coinsurance	Deductible then 40% coinsurance	Cost sharing 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			
	Childbirth/delivery facility services			

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
		In-Network Providers (You will pay the least)	Out-of-Network Providers (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	Deductible then 20% coinsurance	Deductible then 40% coinsurance	Limited to 130 visits/year. No coverage for private duty nursing or custodial care.
	Rehabilitation services			Inpatient: Preauthorization is required. Covered up to 30 days/year. Outpatient: Covered up to 30 visits/year. No coverage for recreation therapy.
	Habilitation services			Inpatient: Preauthorization is required. Covered up to 30 days/year. Outpatient: Covered up to 30 visits/year. No coverage for recreation therapy.
	Skilled nursing care			Limited to 60 days/year. No coverage for custodial care.
	Durable medical equipment			Limited to: one pair/year for glasses or contact lenses; one breast pump/pregnancy; $150/year for wig for chemotherapy or radiation therapy. Preauthorization is required if equipment is over $1,000 and for power-assisted wheelchairs.
	Hospice services			No coverage for private duty nursing.
If your child needs dental or eye care	Children's eye exam	Not covered		
	Children's glasses			
	Children's dental check-up			

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 to save the life of the mother) • Bariatric surgery • Cosmetic surgery • Custodial care	• Dental care (Adult) • Dental check-up (Child) • Hearing aids (Adult) • Infertility treatment • Long-term care	• Non-emergency care when traveling outside the U.S. • Private-duty nursing • Routine eye care (Adult) • Routine foot care, other than with diabetes mellitus • Weight loss programs
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture	• Chiropractic care	• Hearing aids (Child)

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 www.HealthCare.gov or call 1-800-318-2596.

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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 1-866-281-1464.

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**	$2,000
■ **Specialist coinsurance**	20%
■ **Hospital (facility) coinsurance**	20%
■ **Other coinsurance**	20%

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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$0
Coinsurance	$2,100
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,160**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

■ **The plan's overall deductible**	$2,000
■ **Specialist coinsurance**	20%
■ **Hospital (facility) coinsurance**	20%
■ **Other coinsurance**	20%

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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$0
Coinsurance	$700
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,720**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

■ **The plan's overall deductible**	$2,000
■ **Specialist coinsurance**	20%
■ **Hospital (facility) coinsurance**	20%
■ **Other coinsurance**	20%

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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$0
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,200**

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

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, please contact the PacificSource customer service team at 1-888-246-1370. 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 at www.dol.gov/ebsa/healthreform or call 1-888-246-1370 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	All providers: $2,800 individual /$5,200 family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible
Are there services covered before you meet your deductible?	Yes. Preventive care	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	All providers: $5,000 individual /$10,000 family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing 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.
Will you pay less if you use a network provider?	Yes. See http://providerdirectory.PacificSource.com/?nPlan=Voyager or call 1-888-246-1370 for a list of network providers. Please refer to your member id card for the name of your network.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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
		In-Network Providers (You will pay the least)	Out-of-Network Providers (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	Deductible then 20% coinsurance	Deductible then 40% coinsurance	None.
	Specialist visit			
	Preventive care/screening/ immunization	No charge, deductible does not apply	40% coinsurance, deductible does not apply	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 provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Deductible then 20% coinsurance	Deductible then 40% coinsurance	None
	Imaging (CT/PET scans, MRIs)			Preauthorization is required.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **http://PacificSource.com/drug-list/PDL/**	Tier one drugs	Retail and Mail: Deductible then 20% coinsurance		Prescription benefit includes certain outpatient drugs as a preventive benefit at no charge, deductible does not apply. Retail and mail are limited to a 90 day supply. Preauthorization is required for certain drugs. Specialty drugs are limited to 30 day supply.
	Tier two drugs			
	Tier three drugs			
	Specialty drugs	Deductible then $200 copayment/prescription		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory surgery center: Deductible then 10% coinsurance Other facilities: Deductible then 20% coinsurance	Deductible then 40% coinsurance	None
	Physician/surgeon fees			

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
		In-Network Providers (You will pay the least)	Out-of-Network Providers (You will pay the most)	
If you need immediate medical attention	Emergency room care	Deductible then 20% coinsurance		None.
	Emergency medical transportation			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.
	Urgent care	Deductible then 20% coinsurance	Deductible then 40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible then 20% coinsurance	Deductible then 40% coinsurance	Limited to semi-private room unless intensive or coronary care units, medically necessary isolation, or hospital only has private rooms. Preauthorization is required for some inpatient services.
	Physician/surgeon fees			None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Deductible then 20% coinsurance	Deductible then 40% coinsurance	None
	Inpatient services			Preauthorization is required for some inpatient services.
If you are pregnant	Office visits	Deductible then 20% coinsurance	Deductible then 40% coinsurance	Cost sharing 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. This benefit only covers the enrolled employee and the enrolled spouse. Maternity coverage for dependent children is only covered if there is a complication.
	Childbirth/delivery professional services			
	Childbirth/delivery facility services			

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Providers (You will pay the least)	Out-of-Network Providers (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	Deductible then 20% coinsurance	Deductible then 40% coinsurance	Limited to 130 visits/year. No coverage for private duty nursing or custodial care.
	Rehabilitation services			Inpatient: Preauthorization is required. Covered up to 30 days/year. Outpatient: Covered up to 30 visits/year. No coverage for recreation therapy.
	Habilitation services			Inpatient: Preauthorization is required. Covered up to 30 days/year. Outpatient: Covered up to 30 visits/year. No coverage for recreation therapy.
	Skilled nursing care			Limited to 130 visits/year. No coverage for private duty nursing or custodial care.
	Durable medical equipment			Limited to: one pair/year for glasses or contact lenses; one breast pump/pregnancy; $150/year for wig for chemotherapy or radiation therapy. Preauthorization is required if equipment is over $1,000 and for power-assisted wheelchairs.
	Hospice services			No coverage for private duty nursing.
If your child needs dental or eye care	Children's eye exam	Not covered		
	Children's glasses			
	Children's dental check-up			

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 to save the life of the mother) • Bariatric surgery • Cosmetic surgery • Custodial care	• Dental care (Adult) • Dental check-up (Child) • Hearing aids (Adult) • Infertility treatment • Long-term care	• Non-emergency care when traveling outside the U.S. • Private-duty nursing • Routine eye care (Adult) • Routine foot care, other than with diabetes mellitus • Weight loss programs
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture	• Chiropractic care	• Hearing aids (Child)

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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:
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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**	$2,800
■ **Specialist coinsurance**	20%
■ **Hospital (facility) coinsurance**	20%
■ **Other coinsurance**	20%

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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,800
Copayments	$0
Coinsurance	$2,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,860**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

■ **The plan's overall deductible**	$2,800
■ **Specialist coinsurance**	20%
■ **Hospital (facility) coinsurance**	20%
■ **Other coinsurance**	20%

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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$2,800
Copayments	$0
Coinsurance	$500
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$3,320**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

■ **The plan's overall deductible**	$2,800
■ **Specialist coinsurance**	20%
■ **Hospital (facility) coinsurance**	20%
■ **Other coinsurance**	20%

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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

Contact Information

PacificSource HEALTH PLANS	**Medical**	**Pacific Source Health Plans** (888) 246-1370 www.pacificsource.com
DELTA DENTAL	**Voluntary Dental**	**Delta Dental of Idaho** (800) 521-2651 www.deltadentalID.com
Willamette Dental Group	**Voluntary Dental**	**Willamette Dental Group** (855) 433-6825 www.willamettedental.com
vsp Vision care for life	**Voluntary Vision**	**VSP** (800) 877-7195 www.vsp.com
UNITED HERITAGE Insurance	**Life/AD&D Voluntary Life** **Long & Short Term Disability** **Accident & Critical Illness**	**United Heritage** (208) 493-6100 www.unitedheritage.com
Aflac.	**Accident** **Critical Illness** **Cancer**	**AFLAC** (800) 992-3522 www.aflac.com **Karen Ball** (208) 660-7546 karen_ball@us.aflac.com
PacificSource ADMINISTRATORS	**General & Limited Purpose FSA** **Dependent Care FSA** **COBRA**	**Pacific Source Administrators** FSA: (800) 422-7038 COBRA: (877) 355-2760 www.psa.pacificsource.com
Flores	**H.S.A Administration**	**Flores & Associates** (800) 532-1327 www.flores-associates.com
uprisehealth	**Employee Assistance Program (EAP)**	**Uprise Health** (866) 750-1327 www.uprisehealth.com
Wellworks For You	**Wellness Incentive**	**WellWorks for You** (800) 425-4657 www.wellworksforyoulogin.com Company ID: 10925
PayneWest INSURANCE A Marsh & McLennan Agency LLC company	**Benefit Contacts**	**PayneWest Insurance** Jackie Sue McFarlin (509) 363-4040 jmcfarlin@paynewest.com