BONNER COUNTY

mybenefits

2020-2021

Employee Benefit Guide

WHAT'S INSIDE

EMPLOYEE CONTRIBUTION RATES

EFFECTIVE OCTOBER 1, 2020

Employee Per Paycheck Cost *(24 Paychecks)*	Employee	Employee & Spouse	Employee & Child	Employee & Children	Employee & Family
PacificSource Health Plans	*Pre-Tax*				
PPO Base	**$61.58**	**$132.28**	**$87.39**	**$118.13**	**$175.32**
PPO Wellness	**$34.27**	**$92.11**	**$55.38**	**$80.53**	**$127.33**
HSA Base	**$43.97**	**$88.52**	**$58.49**	**$79.07**	**$117.33**
HSA Wellness	**$21.58**	**$58.03**	**$33.46**	**$50.30**	**$81.61**
Delta Dental of Idaho	*Pre-Tax*				
	$2.50	**$5.00**	**$5.00**	**$5.00**	**$7.50**
Willamette Dental Group	*Pre-Tax*				
	$2.50	**$5.00**	**$5.00**	**$5.00**	**$7.50**
United Heritage Vision	*Pre-Tax*				
	$0.00	**$2.70**	**$3.09**	**$3.09**	**$6.52**
Accident	*Post-Tax*				
	$6.49	**$10.24**	**$10.89**	**$10.89**	**$17.14**

Please see page 26 for the Voluntary Life/AD&D Rate Table and page 28 for the Critical Illness Rate Table.

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 2020-2021	Contribution Amount per Year	
Individual HSA Funding ($2,000 HSA plan)	**Non Wellness**	**Wellness**
	$1,500	$1,800
Family HSA Funding ($2,800 HSA plan)		
	$2,000	$2,300

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 outlined on page 20.

Please refer to page 20 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.

If your spouse or any dependent child also work for Bonner County and are eligible for benefits, you each must enroll separately as an employee.

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

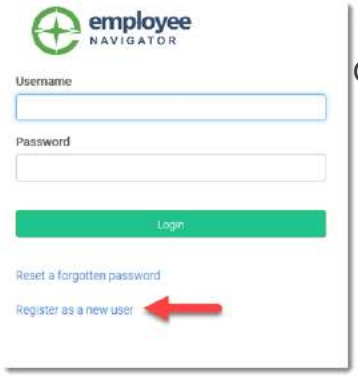
Coverage may be extended to a child named in a Qualified Medical Child Support Order or to a physically or mentally disabled child if the disability occurs before the child reached age 26.

- 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 registered your account since May 2020, please log in with your current username & password.

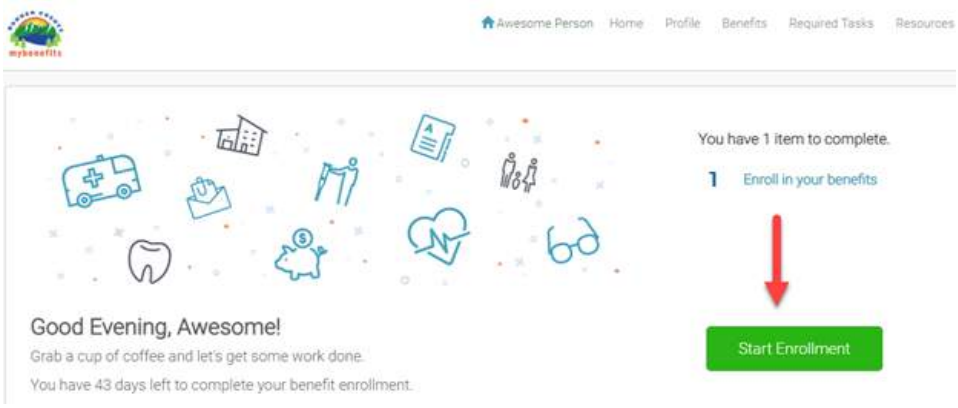
  If you registered prior to May 2020, please register as a new user (create an account, then create username & password).
  TIP: You can re-use your old username & password!

- **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.

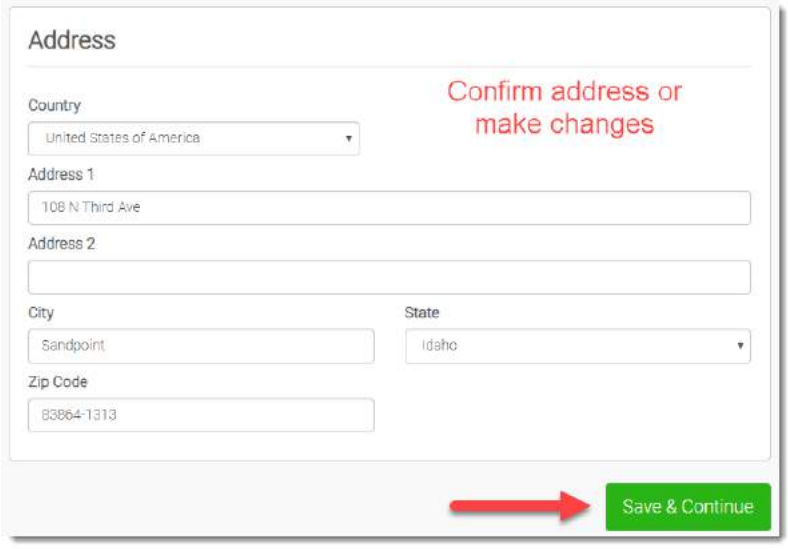
- COMPANY ID: **BonnerCounty**

Step 2: Welcome!

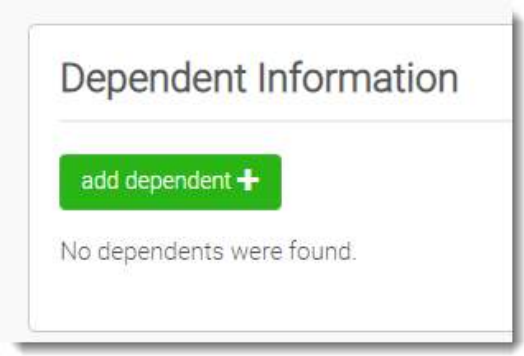
After you login click Start Enrollment



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.

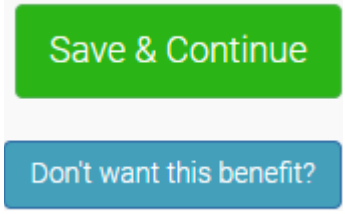
Progress Bar:

Green is complete

Yellow needs an election or a decline

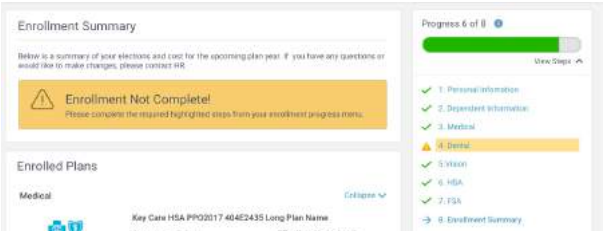
Click **Save & Continue** at the bottom of each screen to save your elections.

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:_____

2020-2021 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 the website or you can contact HR at mybenefits@bonnercountyid.gov.
See page 30 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

PacificSource Preventive Drug List

The Preventive Drug List is included in our individual and small-group plans*, and is an optional benefit for large groups. With this new benefit, the drugs listed below are paid at 100 percent. This list is a separate benefit from preventative service drugs covered under the Affordable Care Act. A full list of covered drugs can be found on our website at PacificSource.com/drug-list.

Show your PacificSource ID card each time you purchase prescriptions at a participating pharmacy to ensure you're receiving the best benefit.

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

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

Bone Health

- alendronate sodium
- ibandronate sodium

Cholesterol

- atorvastatin calcium
- lovastatin
- pravastatin sodium
- simvastatin

Diabetes

- glimepiride
- glipizide
- glipizide ER
- glipizide XL
- glipizide-metformin
- glyburide
- metformin HCL
- metformin HCL ER

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

**Except for the Oregon Standard Bronze, Silver, or Gold plans.*

CLB781_0718

PacificSource Incentive Drug List

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

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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.

On-demand access to doctors via phone, video, or mobile app

As a PacificSource member, you have access to a U.S. board-certified doctor 24 hours a day, 7 days a week, year-round with Teladoc.

- If you are enrolled on the copay health plan your regular office copay will apply.
- If you are enrolled on the HSA health plan a copay equivalent to Fair Market Value will apply.

Talk to a doctor anytime!

Web
Teladoc.com

Phone
(855) 201-7488

Mobile App
Teladoc.com/mobile

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

1. Set up your account

There are three convenient ways to get started. When asked to enter the name of your employer or insurance carrier, please enter PacificSource.

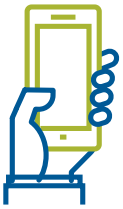
Online: Log in or register with InTouch for Members through PacificSource.com. You'll find the Teladoc Remote link under Tools. This will provide a direct link for you to set up your Teladoc account.

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

By phone: Teladoc can help you register your account over the phone. Call toll-free (855) 201-7488.

2. Provide medical history

Your medical history provides Teladoc doctors with the information they need to make an accurate diagnosis.



3. Request a consult

Once your account is set up, request a consult anytime you need care. And talk to a doctor by phone, web, or mobile app.

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 video consults.

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.

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.

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 abuse.

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.

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.

Online and Mobile Tools

At **PacificSource.com,** and the myPacificSource mobile app, you can access tools, information, and resources to help you make the most of your PacificSource benefits.

InTouch

You can access coverage and benefit information through InTouch, our secure web portal at **PacificSource.com.**
It allows you to easily and conveniently manage your insurance coverage and health, 24/7. Sign into InTouch to:

- Look up coverage information in your member handbook/policy, or read benefit summaries.
- Look up claims.
- View explanations of benefits.
- Review your family's enrollment history.
- Check deductible and your out-of-pocket status.
- Track preauthorizations.
- Look up your share of your family's healthcare expenses.
- Change your address.
- Order replacement ID cards.
- Estimate healthcare costs using our Treatment Cost Navigator.
- Access the CaféWell health and wellness resource.

myPacificSource Mobile App

Our free mobile app gives you secure, on-the-go access
to all your coverage information, no matter where you are. Available for iPhone® and Android™. Visit **PacificSource.com/mobile** for more information.

Health Management Programs and Services

Condition Support

Our Condition Support Program offers education and support to members with asthma, diabetes, heart failure, chronic obstructive pulmonary disease, coronary artery disease, or juvenile diabetes. This program is available to eligible PacificSource members with medical coverage.

AccordantCare

With AccordantCare, we offer rare disease management and specialty pharmacy programs that provide individual support and coordination for our members with certain rare diseases, or those requiring injectable medications or biotech drugs.

Submitting a Claim

Usually, your provider will submit claims for you. If you need to fill a covered prescription or see a provider for a covered service before you receive your new ID card, or if you see a nonparticipating provider, you can pay and then submit a copy of the provider's itemized receipt or statement for reimbursement.

On our website, you'll find details about how to submit a claim. Visit **PacificSource.com/YourPlan/#Claim** for more information.

Value-added Extras

Your Bonner County Health Plan coverage also includes the following no-cost wellness programs and services. For details about these programs and more, visit **PacificSource.com**.

24-Hour NurseLine

Have a health-related question? Our 24-Hour NurseLine is staffed around the clock, 7 days a week—so you'll never be without a registered nurse to talk to. Call them toll-free at (855) 834-6150.

CaféWell

This secure online health engagement portal helps you keep track of, and make the most of, your health. To access CaféWell, sign into InTouch, go to Benefits, and select Wellness – CaféWell.

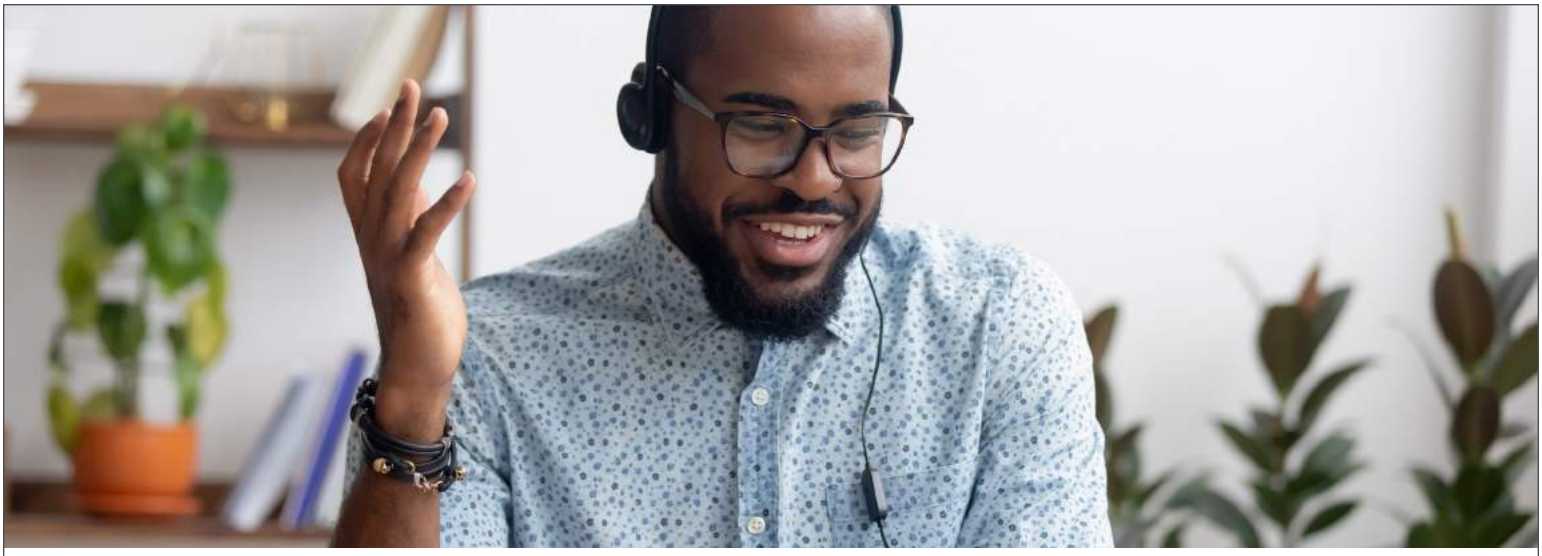
Prenatal Program

If you're expecting, our free Prenatal Program offers you support, useful information, and resources during this very important time for you and your baby.

Prenatal vitamins: Women between the ages of 15 and 45 with prescription drug coverage are eligible to receive select physician-prescribed prenatal vitamins at no cost—all co-pays and deductibles are waived—when filled through an in-network pharmacy. Visit our website for details.

Gym Membership Program

With the Active&Fit® gym membership program, you can access any gym within your plan's network for a one-time initiation fee of $25 plus a monthly fee of $25 per member.



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

Condition Support to Help You **Live Well**

If you've been diagnosed with a chronic condition, our Condition Support program provides you with information and support to take charge of your health.

About the Program

When you're living with a chronic condition, it helps to have reliable resources for information, support, and someone to hold you accountable as you make lifestyle changes. We're here for you. This program offers you the opportunity to talk with a registered nurse or registered dietitian on a regular, ongoing basis for health and wellness coaching.

Here's what you can expect throughout the program:

- You'll learn what you can do to take care of your health and discover what makes you successful.
- We'll guide you in setting health goals that are clear and meaningful to you—and help you stay on track with those goals.
- You'll receive information about medication, health, nutrition, and fitness.
- You'll discover new ways to overcome challenges life throws your way.

Participation Details

As your health insurance company, we receive claims from your doctor for the services you receive, which include a diagnosis to explain those services. We look for specific diagnoses that match with the services that Condition Support offers. This is how we identify eligible participants for the program, and participation is voluntary. There's no additional cost to participate, and you may opt out at any time.

Health Coaching to Support Your Success

To help you reach your wellness goals, you have the option to work with a health coach. Your health coach will be a PacificSource registered nurse or registered dietitian—or possibly both, depending on your individual needs. We ask that you commit to working with your health coach for three months.

Working with a health coach allows you to learn more about your condition when you need it. Together, you and your coach will discover your strengths, successes, motivations, support systems, and obstacles. Coaches help you to create a clear picture of what you would like for your best health, discover your strengths, and learn what really drives you.

Continued on next page >

Idaho
Direct: (208) 333-1596
Toll-free: (800) 688-5008

Montana
Direct: (406) 442-6589
Toll-free: (877) 590-1596

Oregon
Direct: (541) 684-5582
Toll-free: (888) 977-9299

TTY
Toll-free: (800) 735-2900

En Español
Direct: (541) 684-5456
Toll-free: (800) 624-6052
ext. 1009

Email
cs@pacificsource.com

PacificSource.com

PacificSource HEALTH PLANS

If you choose to participate in health coaching, your coach will:

- Help you identify your goals and priorities
- Increase your knowledge about treatments and self-care for your condition
- Work with you to set weekly action items

Health coaching sessions are done by phone at a time and place that works for you.

To get the most from coaching:

- Schedule your call during a time when you are able to comfortably talk about your health and wellness.
- Stay engaged in the conversation, and avoid multitasking.
- Enjoy the time. How often do you get to talk with someone about your personal health goals? Take this time for you, to focus on your self-care.

If you choose to work with a registered nurse or registered dietitian as your health coach, we'll send your doctor or other healthcare provider a letter to inform them about your enrollment in the program and contact with a health coach. We encourage you to share any of the information from this program and your health goals with your provider.

The Condition Support program is meant to be a cooperative effort between you, your healthcare provider, and your PacificSource nurse or health coach.

Learn More about Condition Support

If you want to learn more about our Condition Support program, check eligibility for health coaching, or schedule your initial consultation with a registered nurse, we're here for you. Contact us at **yoursupport@pacificsource.com** or call us at **(888) 987-5805**.

PacificSource HEALTH PLANS

DENTAL INSURANCE

Regular dental care is essential to good health. The Bonner County dental plans are administered through Delta Dental of Idaho and Willamette Dental Group. This offering is 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 Oral Examinations & Cleanings Sealants Topical Fluoride Application Full Mouth & Bitewing X-rays	100% (Deductible Waived)	80% (Deductible Waived)
Basic Restorative Endodontics—Root Canal General Anesthesia Oral Surgery (Simple Extractions) Periodontics/Gum Disease	80%	70%
Major Restorative Implants: Services Implants: Repairs Bridges, Dentures, Crowns/Onlays	50%	40%
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 (CONTINUED)

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.

One difference in 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 Topical Fluoride Application X-rays Fillings Sealants (per tooth) Local Anesthesia Oral Surgery (Simple Extractions) Periodontal Charting & Evaluation	Office Visit Copay Applies
Endodontics & Periodontics Root Canal Therapy—Anterior, Bicuspid, Molar Osseous Surgery (per Quadrant) Bridges, Dentures, Crowns/Inlays/Onlays Nitrous Oxide Periodontal Root Planing	Varying Procedure Copays
Orthodontia Pre-Orthodontia Treatment *Copay credited towards Comprehensive Ortho Treatment copay if patient accepts treatment plan* Comprehensive Orthodontia Treatment	 $150 Copay $2,800 Copay
Dental Implants - NEW!	Benefit Maximum of $1,500 Per Calendar Year

Frequency limitations may apply—see your dental booklet for additional information.
**Dental Implant Surgery is a newly covered benefit and is subject to a benefit maximum. This benefit maximum resets on January 1st.*

VISION

Bonner County offers vision insurance through United Heritage using Vision Service Plan. Bonner County pays the cost of employee coverage. You may choose to pay the cost 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**	Up to $70 Reimbursement
Frequency	24 Months	
Contacts		
Contact Lenses Exam & Fitting	$130 Allowance Up to $60 Copay	Up to $105 Reimbursement
Frequency - in lieu of Lenses & Frames	12 Months	

*20% savings on the amount over your allowance
**Wholesale Allowance - Costco, Wal-Mart and Sam's Club

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

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 Avidia 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. *Any employee who does not take the necessary steps to open their account or complete the identity verifcation within 60 days forfeits their employer contribution from Bonner County into their HSA.*

Contribution Limits

	2020	2021
Employee	$3,550	$3,600
Employee + 1	$7,100	$7,200
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.

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 care 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 2020, contribution limits are:
Flexible Spending Account—$2,750
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 whitenening)
- Orhtodontia
- Glasses and/or Contact Lenses
- Vision Correction Procedures
- Guide Dog or other service animal
- Acupuncture
- Nursing Services
- Prosthesis
- Contraceptives
- Drug or Alcohol Treatment
- Fertility Treatment
- Transplants
- Vasectomy

Examples of Typical INELIGIBLE 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 2020, contribution limits are:
Flexible Spending Account—$2,750
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 INELIGIBLE 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:

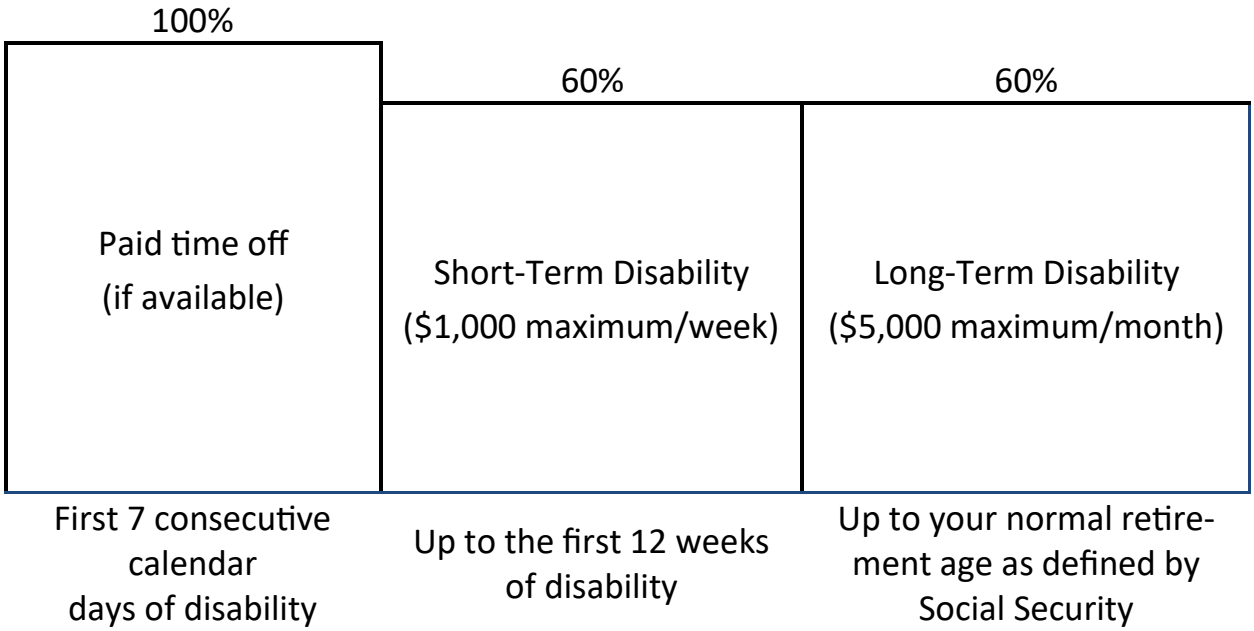
Before STD benefits begin, you may be eligible for paid time off benefits. Please refer to your employee handbook for details on the paid time off policy.

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 and Accidental Death and Dismemberment (AD&D) insurance for employees. Employees also have the option to pay the cost for additional coverage as outlined below.

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 / AD&D 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-26 years	$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 life insurance coverage without Evidence of Insurability to an individual whole 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 Life/AD&D 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 *
Rate per $1,000
$0.22

Follow the method described above to calculate your Voluntary Life/AD&D premiums for yourself and 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 and use the above formula to determine your desired benefit for your spouse.

*Regardless of how many children you have, they are included in the "Child(ren) Unit" premium amounts listed in the table above.

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 you've reached the guaranteed issue limit. This step-up guarantee applies only to employees.

ACCIDENT & CRITICAL ILLNESS

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.

ACCIDENT:

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

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)
- Coma

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

If a family plan 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% of the employee amount for a child
- Children can be enrolled until age 26

CRITICAL ILLNESS

A serious illness can be devastating, and this plan covers 15 of the most common critical illnesses.

In addition to the Critical Illness benefits, this plan will pay you to get your annual preventive exam as well as pays a daily hospital confinement benefit.

The Critical Illness plan does have a **pre-existing condition clause**:

-Any condition diagnosed prior to your coverage effective date will not be covered.
-If treatment for an undiagnosed condition occurs within 6 months prior to your effective date and you later receive a diagnosis, coverage for that condition will not be provided unless diagnosis came after being continuously insured under this contract for at least 12 months.

Category 1:	***Category 2:***	***Category 3:***
Type A Cancer Benefit	*Heart Attack*	*Kidney Failure*
Bone Marrow	*Heart Transplant*	*Major Organ Transplant*
	Stroke	*Loss of Sight, Hearing or Speech*
		Paralysis
		Occupational HIV
		Coma

ACCIDENT & CRITICAL ILLNESS (CONTINUED)

See previous page for introduction to Critical Illness coverage information

Critical Illness Plan Schedule of Benefits (Condensed for Example*)	Benefit Payment
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
Reccurrence Payments *(allowed once per category)*	50% of First Occurrence benefit amount
Lifetime Maximum Benefit Payout	300% of elected benefit amount
Wellness Benefit Rider	Pays $25 Annually for Employee / Spouse Only
Hospital Confinment Rider	Pays $50 per day for hospital confinment

Once a First & Second occurrence have occured in a single category, that category is then closed for future benefits 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	$11.70
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.

EMPLOYEE ASSISTANCE PROGRAM

When you need help balancing work, home, personal or family issues, Bonner County offers value-added programs and services that are of no charge to you.

The Employee Assistance Program (EAP) is offered to all employees and immediate family members of Bonner County through Reliant Behavioral Health. It is a **completely confidential** counseling program that offers 24-hour crisis assistance, and online resources, including the Personal Advantage website and access to counselors online. The names of individuals who seek services through the EAP will never be shared with Bonner County.

You and your immediate family are eligible for up to six (6) face-to-face visits (per member, per occurrence) with a counselor at no charge to you.

The purpose of an EAP is to talk with the individual to define their problem, suggest short-term problem solving steps and refer to other community resources if necessary. In addition, they also provide the following services:

- 24-hour Crisis Help
- In-person Counseling
- Online Consultations
- Mediation Services
- ID Theft Services
- Simple Will Kit
- Home Ownership Program
- Financial Services
- Legal Services, and much more

Their toll-free hotline and website are available 24 hours a day, seven days a week.

Website: MyRBH.com

Phone Number: 1 (866) 750-1327

Access Code: BonnerCounty

WELLWORKS FOR YOU

All Bonner County employees enrolled in medical benefits have opportunities to participate in various wellness activities that can reward you with a reduced health insurance premium.

New for 2020: In addition to a reduced health insurance premium, employees who complete the Wellness Program steps will receive an additional $300 into their HSA Bank Account. If you're enrolled on the Copay plan or ineligible for HSA Banking contributions, the County will establish an HRA VEBA Account on your behalf and contribute $300 into the account if you complete the Wellness Program steps.

Please refer to your WellWorks For You brochure for additional information.

OVERVIEW

Complete Steps 1-4 listed below **on or before July 31, 2021** to be eligible for health premium discounts and the additional new financial incentives noted above:

- ✓ **Step 1**—Participate in an Onsite Biometric Screening event, complete Biometrics with lab work with White Cross Pharmacy, or with your Primary Care Provider. You only need to complete **one** of these options.
- ✓ **Step 2**—Complete your Annual Wellness Visit with your Primary Care Provider (Proof of Visit Form)
- ✓ **Step 3**—Complete the Know Your Number Assessment located on the Wellness Portal
- ✓ **Step 4**— Complete the Tobacco Attestation Form (and Tobacco Cessation Program, if applicable)

You will no longer be required to wait until the next plan year to receive your incentive!

- Health insurance premium reductions will be effective the 1st of the month following 30 days from completion of the Wellness Program requirements.

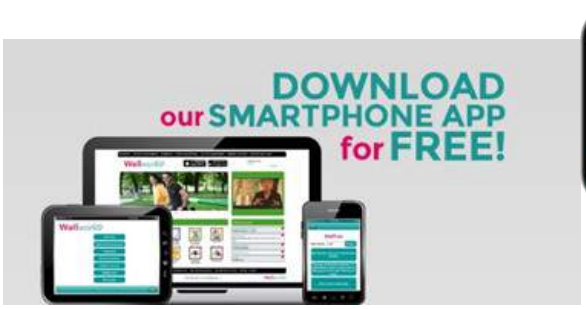
-HSA or HRA funding will occur quarterly
(August-October / November-January / February-April / May-July)

WELLNESS PORTAL

In order for your participation in the program to be tracked, employees are required to have a WellWorks For You Wellness Portal account. If you already have an account, you DO NOT need to create a new one.

If you do not have an account, please refer to your brochure to register. **In accordance with HIPAA confidentiality laws, your individual data is accessible only to you and the third party vendor, WellWorks For You.**

Download the 'Wellworks for You' mobile app for your one stop shop access to your wellness portal!



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 July 31, 2016. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
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	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.hip.in.gov Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Medicaid	**IOWA – Medicaid**
Medicaid Website: http://www.colorado.gov/hcpf Medicaid Customer Contact Center: 1-800-221-3943	Website: http://www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562

KANSAS – Medicaid	NEVADA – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900
KENTUCKY – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
LOUISIANA – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	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
MAINE – Medicaid	**NEW YORK – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public- assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MASSACHUSETTS – Medicaid and CHIP	**NORTH CAROLINA – Medicaid**
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MINNESOTA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: http://mn.gov/dhs/ma/ Phone: 1-800-657-3739	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MISSOURI – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.ht m Phone: 573-751-2005	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MONTANA – Medicaid	**OREGON – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIP P Phone: 1-800-694-3084	Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-800-699-9075
NEBRASKA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dhhs.ne.gov/Children_Family_Services/AccessNe braska/Pages/accessnebraska_index.aspx Phone: 1-855-632-7633	Website: http://www.dhs.pa.gov/hipp Phone: 1-800-692-7462

RHODE ISLAND – Medicaid	VIRGINIA – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/ Phone: 401-462-5300	Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282
SOUTH CAROLINA – Medicaid	**WASHINGTON – Medicaid**
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx Phone: 1-800-562-3022 ext. 15473
SOUTH DAKOTA - Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx Phone: 1-877-598-5820, HMS Third Party Liability
TEXAS – Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
UTAH – Medicaid and CHIP	**WYOMING – Medicaid**
Website: Medicaid: http://health.utah.gov/medicaid CHIP: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VERMONT– Medicaid	
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	

To see if any other states have added a premium assistance program since July 31, 2016, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/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

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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 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.
	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 you need 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: $30 copayment/prescription, deductible does not apply 60 day supply: $60 copayment/prescription, deductible does not apply 90 day supply: $90 copayment/prescription, deductible does not apply Mail: $90 copayment/prescription, deductible does not apply		

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)	
	Tier three drugs	Retail: 30 day supply: $45 copayment/prescription, deductible does not apply 60 day supply: $90 copayment/prescription, deductible does not apply 90 day supply: $135 copayment/prescription, deductible does not apply Mail: $135 copayment/prescription, deductible does not apply		
	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

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 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			Limited to 130 visits/year. No coverage for private duty nursing or custodial care. Preauthorization is required.

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)	
	Rehabilitation services	Deductible then 20% coinsurance	Deductible then 40% coinsurance	Inpatient: Preauthorization is required. Covered up to 30 days/year, additional days may be preauthorized. Outpatient: Covered up to 30 visits/year, additional visits may be preauthorized. No coverage for recreation therapy.
	Habilitation services			Inpatient: Preauthorization is required. Covered up to 30 days/year, additional days may be preauthorized. Outpatient: Covered up to 30 visits/year, additional visits may be preauthorized. 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 of rape, incest or to save the life of the mother) • Bariatric surgery • Cosmetic surgery • Custodial care	• Dental care (Adult) • Dental check-up (Child) • Hearing aids • 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	

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

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

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-866-281-1464.

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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$100
Coinsurance	$2,500
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	$1,500
Specialist copayment	$45
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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,300
Copayments	$1,400
Coinsurance	$300
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$3,060**

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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,300
Copayments	$100
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,700**

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

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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 you need 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		

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory surgery center: Deductible then 10% coinsurance	Deductible then 40% coinsurance	None
	Physician/surgeon fees	Other facilities: Deductible then 20% coinsurance		
If you need immediate medical attention	Emergency room care	Deductible then 20% coinsurance		None.
	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	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.

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 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			
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. Preauthorization is required.
	Rehabilitation services			Inpatient: Preauthorization is required. Covered up to 30 days/year, additional days may be preauthorized. Outpatient: Covered up to 30 visits/year, additional visits may be preauthorized. No coverage for recreation therapy.
	Habilitation services			Inpatient: Preauthorization is required. Covered up to 30 days/year, additional days may be preauthorized. Outpatient: Covered up to 30 visits/year, additional visits may be preauthorized. No coverage for recreation therapy.
	Skilled nursing care			Limited to 60 days/year. No coverage for custodial care.

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)	
	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 of rape, incest or to save the life of the mother)
- Bariatric surgery
- Cosmetic surgery
- Custodial care
- Dental care (Adult)
- Dental check-up (Child)
- Hearing aids
- 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

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

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

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-866-281-1464.

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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$0
Coinsurance	$2,500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,560**

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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$0
Coinsurance	$1,400
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$3,460**

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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$0
Coinsurance	$400
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 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 you need 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		

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 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 20% coinsurance		None.
	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	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.

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 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. Preauthorization is required.
	Rehabilitation services			Inpatient: Preauthorization is required. Covered up to 30 days/year, additional days may be preauthorized. Outpatient: Covered up to 30 visits/year, additional visits may be preauthorized. No coverage for recreation therapy.
	Habilitation services			Inpatient: Preauthorization is required. Covered up to 30 days/year, additional days may be preauthorized. Outpatient: Covered up to 30 visits/year, additional visits may be preauthorized. No coverage for recreation therapy.

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)	
	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 of rape, incest or to save the life of the mother)
- Bariatric surgery
- Cosmetic surgery
- Custodial care
- Dental care (Adult)
- Dental check-up (Child)
- Hearing aids
- 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

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

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

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-866-281-1464.

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	$2,800
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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,800
Copayments	$0
Coinsurance	$2,200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,060**

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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$2,800
Copayments	$0
Coinsurance	$1,400
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$4,260**

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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$0
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,900**

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

Contact Information

PayneWest INSURANCE	**Benefit Contacts**	**PayneWest Insurance** Josh Peterson, Sales Executive Bre Lassiter, Senior Account Manager (208) 770-3200 blassiter@paynewest.com
BONNER COUNTY mybenefits	**Bonner County Benefits Administration**	**Benefits Administration** (208) 265-1456 mybenefits@bonnercountyid.gov
PacificSource HEALTH PLANS	**Medical & Pharmacy**	**Pacifc Source Health Plans** (888) 246-1370 www.pacifcsource.com
PacificSource ADMINISTRATORS	**General & Limited Purpose FSA** **Dependent Care FSA** **COBRA**	**Pacifc Source Administrators** FSA: (800) 422-7038 COBRA: (877)355-2760 www.psa.pacifcsource.com
Flores Better Benefits Experience.	**H.S.A Administration**	Flores **Associates** (800) 532-3327 www.flores-associates.com
DELTA DENTAL	**Dental**	**Delta Dental of Idaho** (800) 356-7586 www.deltadentalid.com
Willamette Dental Group	**Dental**	**Willamette Dental Group** (855) 433-6825 www.willamettedental.com
vsp Vision care for life	**Vision**	**VSP** (800) 877-7195 www.vsp.com
UNITED HERITAGE Insurance	**Life / AD&D** **Long & Short Term Disability** **Accident** **Critical Illness**	**United Heritage** (208) 493-6100 www.unitedheritage.com
RBH Reliant Behavioral Health	**Employee Assistance Program (EAP)** **Wellness**	**Reliant Behavioral Health** (866) 750-1327 www.myrbh.com **WellWorks for You** Tori Bauver (610) 249-0038 t.bauver@wellworksforyou.com

The information in this Benefit Summary is presented for illustrative purposes and is based on information provided by the employer. The text contained in this Summary was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. In case of discrepancy between this Benefits Summary and the actual plan documents, the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have questions about this summary, contact HR.

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