This outline of coverage provides a very brief description of important policy features. Please note this outline is not intended to be part of the insurance contract. Only the actual policy provisions are final and binding. The policy details your rights and obligations, as well as those of PacificSource.

PLEASE READ YOUR MEMBER HANDBOOK CAREFULLY.

Provider Network: PSN

Annual Deductible	Per Person, Per Calendar Year	Per Family, Per Calendar Year
Participating Providers	$4,000	$8,000
Non-participating Providers	$10,000	$20,000
Out-of-Pocket Limit	**Per Person, Per Calendar Year**	**Per Family, Per Calendar Year**
Participating Providers	$4,000	$8,000
Non-participating Providers	$20,000	$40,000
Please note: Your actual costs for services provided by a non-participating provider may exceed this policy's out-of-pocket limit for non-participating services. In addition, non-participating providers can bill you for the difference between the amount charged by the provider and the amount allowed by the insurance company, and this amount is not counted toward the non-participating out-of-pocket limit.		

Trend Data

PacificSource bases large group premiums on data accumulated from the entire Montana large group population. Certain factors such as demographics are incorporated into the rating process. PacificSource bases trend projections on a combination of PacificSource Montana large group data and the PacificSource Oregon book of business. The large group premium increases for the last five years were 2016 15.0%, 2015 4.6%, 2014 10.1%, 2013 9.7%, and 2012 8.3%.

The member is responsible for the above deductible and the following amounts:

Service	Participating Providers:	Non-participating Providers:
Preventive Care		
Well baby/Well child care	No charge*	25% co-insurance*
Routine physicals	No charge*	25% co-insurance*
Well woman visits	No charge*	No charge*
Routine mammograms	No charge*	No charge*
Immunizations	No charge*	No charge*
Routine colonoscopy	No charge*	Deductible then 25% co-insurance
Prostate cancer screening	No charge*	25% co-insurance*
Professional Services		
Office and home visits	Deductible then No charge	Deductible then 25% co-insurance
Naturopath office visits	Deductible then No charge	Deductible then 25% co-insurance
Specialist office and home visits	Deductible then No charge	Deductible then 25% co-insurance

Service	Participating Providers:	Non-participating Providers:
Office procedures and supplies	Deductible then No charge	Deductible then 25% co-insurance
Surgery	Deductible then No charge	Deductible then 25% co-insurance
Outpatient rehabilitation services	Deductible then No charge	Deductible then 25% co-insurance
Hospital Services		
Inpatient room and board	Deductible then No charge	Deductible then 25% co-insurance
Inpatient rehabilitation services	Deductible then No charge	Deductible then 25% co-insurance
Skilled nursing facility care	Deductible then No charge	Deductible then 25% co-insurance
Outpatient Services		
Outpatient surgery/services	Deductible then No charge	Deductible then 25% co-insurance
Advanced diagnostic imaging	Deductible then No charge	Deductible then 25% co-insurance
Diagnostic and therapeutic radiology/lab	Deductible then No charge	Deductible then 25% co-insurance
Urgent and Emergency Services		
Urgent care center visits	Deductible then No charge	Deductible then 25% co-insurance
Emergency room visits – medical emergency	Deductible then No charge	Deductible then No charge
Emergency room visits – non-emergency	Deductible then No charge	Deductible then 25% co-insurance
Ambulance, ground	Deductible then No charge	Deductible then No charge
Ambulance, air	Deductible then No charge	Deductible then No charge+
Maternity Services		
Physician/Provider services (global charge)	Deductible then No charge	Deductible then 25% co-insurance
Hospital/Facility services	Deductible then No charge	Deductible then 25% co-insurance
Mental Health/Chemical Dependency Services		
Office visits	Deductible then No charge	Deductible then 25% co-insurance
Inpatient care	Deductible then No charge	Deductible then 25% co-insurance
Residential programs	Deductible then No charge	Deductible then 25% co-insurance
Other Covered Services		
Allergy injections	Deductible then No charge	Deductible then 25% co-insurance
Durable medical equipment	Deductible then No charge	Deductible then 25% co-insurance

Service	Participating Providers:	Non-participating Providers:
Home health care	Deductible then No charge	Deductible then 25% co-insurance
Chiropractic manipulations and acupuncture	Deductible then No charge	Deductible then 25% co-insurance
Transplants	Deductible then No charge	Deductible then 25% co-insurance

This is a brief summary of benefits. Refer to your handbook for additional information or a further explanation of benefits, limitations, and exclusions.

* Not subject to annual deductible.

\+ Please note that non-participating air ambulance coverage is covered at 200 percent of the Medicare allowable. Contact Customer Service with questions.

Additional Information

What is the annual deductible?

Your plan's deductible is the amount of money that you pay first, before your plan starts to pay. You'll see that many services, especially preventive care, are covered by the plan without you needing to meet the deductible. The individual deductible applies if you enroll without dependents. If you and one or more dependents enroll, the individual deductible applies for each member only until the family deductible has been met. Deductible expense is applied to the out-of-pocket limit.

Note that there is a separate category for participating and non-participating providers when it comes to meeting your deductible. Only participating provider expense applies to the participating provider deductible and only non-participating provider expense applies to the non-participating provider deductible.

What is the out-of-pocket limit?

The out-of-pocket limit is the most you'll pay for covered medical expenses during the plan year. Once the out-of-pocket limit has been met, the plan will pay 100 percent of covered charges for the rest of that year. The individual out-of-pocket limit applies only if you enroll without dependents. If you and one or more dependents enroll, the individual out-of-pocket limit applies for each member only until the family out-of-pocket limit has been met. Be sure to check your Member Handbook, as there are some charges, such as non-essential health benefits, penalties and balance billed amounts that do not count toward the out-of-pocket limit.

Note that there is a separate category for participating and non-participating providers when it comes to meeting your out-of-pocket limit. Only participating provider expense applies to the participating provider out-of-pocket limit. Only non-participating provider expense applies to the non-participating provider out-of-pocket limit.

Payments to providers

Payment to providers is based on the prevailing or contracted PacificSource fee allowance for covered services. Participating providers accept the fee allowance as payment in full. Non-participating providers are allowed to balance bill any remaining balance that your plan did not cover. Services of non-participating providers could result in out-of-pocket expense in addition to the percentage indicated.

Allowable fee for non-participating providers

Outside the PacificSource service area and in areas where our members do not have reasonable access to a participating provider through one of our third party provider networks, the allowable fee, depending upon the services and supply, will be based on the use of the UCR or the participating provider contracted rate, whichever is greater. For more detailed information, please refer to the Non-participating Providers section of your policy.

Preauthorization

Coverage of certain medical services and surgical procedures requires a benefit determination by PacificSource before the services are performed. This process is called 'preauthorization'. Preauthorization is necessary to determine if certain services and supplies are covered under this plan, and if you meet the plan's eligibility requirements. You'll find the most current preauthorization list on our website, PacificSource.com.

The Patient's right to know the costs of medical procedures.

The insured, or the insured's agent, may request an estimate of the member's portion of provider charges for any service or course of treatment that exceeds $500. PacificSource shall make a good faith effort to provide accurate information based on cost estimates and procedure codes obtained by the insured from the insured's health care provider. The estimate may be provided in writing or electronically. It is not a binding contract between PacificSource and the member, and is not a guarantee that the estimated amount will be the charged amount, or that it will include charges for unforeseen conditions. Contact Customer Service at (877) 590-1596 to request an estimate.

Emergency medical conditions

For emergency medical conditions, non-participating providers are paid at the participating provider level.

Emergency medical condition means a medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain that a prudent layperson possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would place the health of a person, or an unborn child in the case of a pregnant woman, in serious jeopardy, result in serious impairment to bodily functions; or result in serious dysfunction of any bodily organ or part. With respect to a pregnant woman who is having contractions, for which there is inadequate time to affect a safe transfer to another hospital before delivery or for which a transfer may pose a threat to the health or safety of the woman or the unborn child.

This PacificSource health plan includes coverage for prescription drugs and certain other pharmaceuticals, subject to the information below. This benefit includes some drugs required by federal health care reform.

MEDICAL PLAN DEDUCTIBLE

You must satisfy the medical plan deductibles, which are shown on the Medical Benefit Summary, before your prescription drug benefits begin for prescription drugs.

The amount you pay for covered prescriptions at participating and non-participating pharmacies applies toward your plan's participating medical out-of-pocket limit, which is shown on the Medical Benefit Summary. The co-payment and/or co-insurance for prescription drugs obtained from a participating or non-participating pharmacy are waived during the remainder of the calendar year in which you have satisfied the medical out-of-pocket limit.

Each time a covered pharmaceutical is dispensed, you are responsible for the amounts below:

	Tier 1:	Tier 2:	Tier 3:
Participating Retail Pharmacy^			
Up to a 30 day supply:	Deductible then No charge	Deductible then No charge	Deductible then No charge
Participating Mail Order Pharmacy			
Up to a 90 day supply:	Deductible then No charge	Deductible then No charge	Deductible then No charge
Non-participating Pharmacy			
30 day max fill, no more than three fills allowed per year:	Deductible then 90% co-insurance		
Tier 4 Specialty Drugs – Participating Specialty Pharmacy			
Up to a 30 day supply:	Deductible then No charge		
Tier 4 Specialty Drugs – Not filled through Participating Specialty Pharmacy			
30 day max fill, no more than three fills allowed per year:	Deductible then 90% co-insurance		
Compound Drugs**			
Up to a 30 day supply:	Deductible then No charge		

^ *Remember to show your PacificSource ID Card each time you fill a prescription at a retail pharmacy. If your ID card is not used, your benefits cannot be applied.*

***Compounded medications are subject to a prior authorization process. Compounds are generally covered only when all commercially available formulary products have been exhausted and all the ingredients in the compounded medication are on the applicable formulary.*

MAC B - Unless the prescribing provider requires the use of a brand name drug, the prescription will automatically be filled with a generic drug when available and permissible by state law. If you receive a brand name drug when a generic is available, you will be responsible for the brand name drug's co-payment and/or co-insurance plus the difference in cost between the brand name drug and its generic equivalent after the deductible is met. If your prescribing provider requires the use of a brand name drug, the prescription will be filled with the brand name drug and you will be responsible for the brand name drug's co-payment and/or co-insurance after the deductible is met. The cost difference between the brand name and generic drug does not apply toward the medical plan's deductible or out-of-pocket limit.

See your member handbook for important information about your prescription drug benefit, including which drugs are covered, limitations, and more.