This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at PacificSource.com/montana/large-group-plan-details-2017-Jan or by calling 1-877-590-1596.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Participating provider: $1,000 person / $2,000 family | Non-participating provider: $5,000 person / $10,000 family Doesn't apply to: Preventive care except preventive colonoscopies from a non-participating provider. Participating provider: office visits.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. Participating provider: $5,000 person / $10,000 family | Non-participating provider $10,000 person / $20,000 family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed 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**.
Does this plan use a network of providers?	Yes. For a list of **preferred providers**, see PacificSource.com or call **1-877-590-1596.**	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some services this plan doesn't cover are listed under the **Excluded Services & Other Covered Services** of this SBC. See your policy or plan document for additional information about **excluded services**.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **participating providers** by charging you lower **deductibles, co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 co-pay/visit	Deductible then 50% co-insurance	---none---
	Specialist visit	$20 co-pay/visit	Deductible then 50% co-insurance	---none---
	Other practitioner office visit	$20 co-pay/visit	Deductible then 50% co-insurance	Acupuncture and Chiropractic Care: limited to a combined fifteen visits. No coverage for homeopathic medicines, supplies, or massage therapy.
	Preventive care/screening/immunization	No charge	50% co-insurance Well women visits/Immunizations: No charge Routine colonoscopy: Deductible then 50% co-insurance Tobacco Cessation: Not covered	Limited to: Routine Physicals: 1 hospital visit at birth, as recommended by child's pediatrician ages 0-7, annually ages 8 and older. Well Woman Visits: annually. Immunizations: CDC and USPSTF Preventive Care Grade A and B Recommended.
If you have a test	Diagnostic test (x-ray, blood work)	Deductible then 20% co-insurance	Deductible then 50% co-insurance	---none---
	Imaging (CT/PET scans, MRIs)	Deductible then 20% co-insurance	Deductible then 50% co-insurance	Pre-authorization required

If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at PacificSource.com.	Tier one drugs	Retail: Rider available for purchase Mail: Rider available for purchase	Rider available for purchase	Rider available for purchase
	Tier two brand drugs	Retail: Rider available for purchase Mail: Rider available for purchase	Rider available for purchase	Rider available for purchase
	Tier three drugs	Retail: Rider available for purchase Mail: Rider available for purchase	Rider available for purchase	Rider available for purchase
	Tier four specialty drugs	Rider available for purchase	Rider available for purchase	Rider available for purchase
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible then 20% co-insurance	Deductible then 50% co-insurance	---none---
	Physician/surgeon fees	Deductible then 20% co-insurance	Deductible then 50% co-insurance	---none---
If you need immediate medical attention	Emergency room services	Medical Emergency: Deductible then $100 co-pay/visit plus 20% co-insurance^ Non-Emergency: Deductible then $100 co-pay/visit plus 20% co-insurance^	Medical Emergency: Deductible then $100 co-pay/visit plus 20% co-insurance^ Non-Emergency: Deductible then 50% co-insurance	Co-pay waived if admitted. For emergency medical conditions only.
	Emergency medical transportation	Deductible then 20% co-insurance	Deductible then 20% co-insurance	Limited to nearest facility able to treat condition. Air covered if ground medically or physically inappropriate. Non-participating air covered up to 200 percent of Medicare allowance.

	Urgent care	$20 co-pay/visit	Deductible then 50% co-insurance	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible then 20% co-insurance	Deductible then 50% co-insurance	Limited to semi-private room unless intensive or coronary care units, medically necessary isolation, or hospital only has private rooms. Pre-authorization required for some inpatient services.
	Physician/surgeon fee	Deductible then 20% co-insurance	Deductible then 50% co-insurance	---none---
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$20 co-pay/visit	Deductible then 50% co-insurance	---none---
	Mental/Behavioral health inpatient services	Deductible then 20% co-insurance	Deductible then 50% co-insurance	Pre-authorization required.
	Substance use disorder outpatient services	$20 co-pay/visit	Deductible then 50% co-insurance	---none---
	Substance use disorder inpatient services	Deductible then 20% co-insurance	Deductible then 50% co-insurance	Pre-authorization required.
If you are pregnant	Prenatal and postnatal care	Deductible then 20% co-insurance	Deductible then 50% co-insurance	Preventive prenatal: No co-insurance.
	Delivery and all inpatient services	Deductible then 20% co-insurance	Deductible then 50% co-insurance	Practitioner delivery and hospital visits are covered under prenatal and postnatal care. Facility is covered the same as any other hospital services. Coverage includes termination of pregnancy.
If you need help recovering or have other special health needs	Home health care	Deductible then 20% co-insurance	Deductible then 50% co-insurance	Limited to 180 days/year. No coverage for private duty nursing or custodial care. Pre-authorization required.
	Rehabilitation services	Inpatient: Deductible then 20% co-insurance Outpatient: Deductible then 20% co-insurance	Inpatient: Deductible then 50% co-insurance Outpatient: Deductible then 50% co-insurance	Inpatient: Limited to 30 days/year; additional visits may be pre-authorized. Pre-authorization required. Outpatient: Limited to 30 visits/year, additional visits may be pre-authorized. No coverage for recreation therapy.
	Habilitation services	Inpatient: Deductible then	Inpatient: Deductible then	Inpatient: Limited to 30 days/year; additional visits may be pre-authorized.

		20% co-insurance Outpatient: Deductible then 20% co-insurance	50% co-insurance Outpatient: Deductible then 50% co-insurance	Pre-authorization required. Outpatient: Limited to 30 visits/year, additional visits may be pre-authorized. No coverage for recreation therapy.
	Skilled nursing care	Deductible then 20% co-insurance	Deductible then 50% co-insurance	Limited to 60 days/year. No coverage for custodial care. Pre-authorization required.
	Durable medical equipment	Deductible then 20% co-insurance	Deductible then 50% co-insurance	Limited to: $5,000/year overall; pre-authorization required for power-assisted wheelchairs; one pair/year for glasses or contact lenses to correct a specific vision defect from a severe medical or surgical problem; one breast pump/pregnancy; and $150/year for wigs for chemotherapy or radiation therapy. Pre-authorization required if over $800. No coverage for hearing aids.
	Hospice service	Deductible then 20% co-insurance	Deductible then 50% co-insurance	Pre-authorization required. No coverage for private duty nursing.
If your child needs dental or eye care	Eye exam	Rider available for purchase	Rider available for purchase	Rider available for purchase
	Glasses	Rider available for purchase	Rider available for purchase	Rider available for purchase
	Dental check-up	Not covered	Not covered	Not covered

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Bariatric Surgery
- Cosmetic Surgery (Except medically necessary or certain reconstructive surgeries)
- Custodial Care
- Dental Care (Adult)
- Dental Check-up(Child)
- Hearing Aids (Adult)
- Hearing Aids (Child)
- Infertility Treatment
- Long-term care
- Massage Therapy
- Non-emergency care when traveling outside the U.S.
- Outpatient Recreational Therapy
- Private Duty Nursing
- Routine eye care (Adult)
- Routine foot care, other than with diabetes mellitus

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture
- Chiropractic Care
- Weight loss programs

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at **1-877-590-1596**. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact the PacificSource Customer Service Department at 1-877-590-1596. For group health coverage subject to ERISA, you can also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact the Montana Commissioner of Securities and Insurance at 1-406-444-2040 or toll-free at 1-800-332-6148.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage". **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-877-590-1596.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,120
- **Patient pays** $2,420

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$1,000
Co-pays	$0
Co-insurance	$1,250
Limits or exclusions	$170
Total	**$2,420**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $1,180
- **Patient pays** $4,220

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$1,000
Co-pays	$100
Co-insurance	$190
Limits or exclusions	$2,930
Total	**$4,220**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact; 1-877-590-1596.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles, co-payments,** and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments, deductibles,** and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.