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/individual-plan-details-2017 or by calling 1-877-590-1596.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Participating provider: $3,000 person/$6,000 family | Non-participating provider: $6,000 person/$12,000 family Doesn't apply to: 1st $150 pediatric vision hardware. Participating provider services: preventive care; pediatric vision exam; preventive Rx drugs. Non-participating provider services: 1st $40 pediatric vision exam; well baby/child care; routine mammograms.	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	Deductible then 25% co-insurance	Deductible then 50% co-insurance	---none---
	Specialist visit	Deductible then 25% co-insurance	Deductible then 50% co-insurance	---none---
	Other practitioner office visit	Deductible then 25% co-insurance	Deductible then 50% co-insurance	Acupuncture: Limited to 12 visits/year. Chiropractic Manipulation: Limited to 10 visits/year. No coverage for homeopathic medicines, supplies, or massage therapy.
	Preventive care/screening/immunization	No charge	Deductible then 25% co-insurance Routine Mammograms: No charge Well Baby/Well Child Care: 25% 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 25% co-insurance	Deductible then 50% co-insurance	---none---

	Imaging (CT/PET scans, MRIs)	Deductible then 25% 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: Deductible then 25% co-insurance Mail: Deductible then 25% co-insurance	Deductible then 50% co-insurance	Retail limited to 30 day supply. Mail limited to 90 day supply. Pre-authorization required for certain drugs.
	Tier two drugs	Retail: Deductible then 25% co-insurance Mail: Deductible then 25% co-insurance	Deductible then 50% co-insurance	See Tier one drugs above.
	Tier three brand drugs	Retail: Deductible then 25% co-insurance Mail: Deductible then 25% co-insurance	Deductible then 50% co-insurance	See Tier one drugs above.
	Tier four specialty drugs	Deductible then 25% co-insurance	Deductible then 50% co-insurance	Participating provider benefit available only through our specialty pharmacy services provider. Limited to 30 day supply. Pre-authorization required for certain drugs.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible then 25% co-insurance	Deductible then 50% co-insurance	---none---
	Physician/surgeon fees	Deductible then 25% co-insurance	Deductible then 50% co-insurance	---none---
If you need immediate medical attention	Emergency room services	Medical Emergency: Deductible then 25% co-insurance Non-Emergency: Deductible then 25% co-insurance	Medical Emergency: Deductible then 25% co-insurance Non-Emergency: Deductible then 50% co-insurance	---none---

	Emergency medical transportation	Deductible then 25% co-insurance	Deductible then 25% 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% of Medicare allowance.
	Urgent care	Deductible then 25% co-insurance	Deductible then 50% co-insurance	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible then 25% 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 25% co-insurance	Deductible then 50% co-insurance	---none---
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Deductible then 25% co-insurance	Deductible then 50% co-insurance	---none---
	Mental/Behavioral health inpatient services	Deductible then 25% co-insurance	Deductible then 50% co-insurance	Pre-authorization required.
	Substance use disorder outpatient services	Deductible then 25% co-insurance	Deductible then 50% co-insurance	---none---
	Substance use disorder inpatient services	Deductible then 25% co-insurance	Deductible then 50% co-insurance	Pre-authorization required.
If you are pregnant	Prenatal and postnatal care	Deductible then 25% co-insurance	Deductible then 50% co-insurance	Preventive prenatal: No co-insurance.
	Delivery and all inpatient services	Deductible then 25% 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 25% 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:	Inpatient:	Inpatient: Pre-authorization required.

		Deductible then 25% co-insurance Outpatient: Deductible then 25% co-insurance	Deductible then 50% co-insurance Outpatient: Deductible then 50% co-insurance	Outpatient: No coverage for recreation therapy.
	Habilitation services	Inpatient: Deductible then 25% co-insurance Outpatient: Deductible then 25% co-insurance	Inpatient: Deductible then 50% co-insurance Outpatient: Deductible then 50% co-insurance	Inpatient: Pre-authorization required. Outpatient: No coverage for recreation therapy.
	Skilled nursing care	Deductible then 25% 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 25% 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 wig for chemotherapy or radiation therapy. Pre-authorization required if over $800.
	Hospice service	Deductible then 25% 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	No charge	No charge up to $40 maximum then 100% co-insurance	One routine eye exam/year for age 18 or younger.
	Glasses	Combined participating and non-participating: No charge up to $150 maximum then Deductible then 25% co-insurance	Combined participating and non-participating: No charge up to $150 maximum then Deductible then 25% co-insurance	Combined participating and non-participating: One pair of glasses (frames and lenses) or contact lenses in lieu of glasses/year for age 18 or younger. Additional coatings not covered.
	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 Check-up(Child)
- Hearing Aids (Adult)
- Hearing Aids (Child)
- 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
- Infertility Treatment (Except for reversal of sterilization and in vitro fertilization)
- Weight Loss Programs

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at **1-877-590-1596**. You may also contact your state insurance department by calling 1-406-444-2040 or toll free at 1-800 332-6148; or by writing to Montana Office of the Commissioner of Securities and Insurance, 840 Helena Ave, Helena, MT 59601.

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. Additionally, a consumer assistance program can help you file your appeal. Contact the Montana Office of the 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** $3,320
- **Patient pays** $4,220

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	$3,000
Co-pays	$0
Co-insurance	$1,070
Limits or exclusions	$150
Total	$4,220

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

- **Amount owed to providers:** $5,400
- **Plan pays** $1,750
- **Patient pays** $3,650

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	$3,000
Co-pays	$0
Co-insurance	$570
Limits or exclusions	$80
Total	**$3,650**

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.

American Indian and Native American Benefits: If you are a Native American enrolled on this plan and receive services directly from the Indian Health Service, Indian Tribe, Tribal Organizations, or Urban Indian Organization, or through referral under the contract health services, the services will not be subject to any Deductible, Co-payments, or Co-insurance.

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.