




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, go to <https://PacificSource.com/montana/small-group-plan-details-2018>. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary <http://www.dol.gov/ebsa/healthreform> or call 1-877-590-1596 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|--|--|
| What is the overall <u>deductible</u>? | Participating <u>provider</u> : \$4,000 person/\$8,000 family Non-participating <u>provider</u> : \$8,000 person/\$16,000 family | Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> . |
| Are there services covered before you meet your <u>deductible</u>? | Yes. Participating: <u>preventive care</u> ; office visits. Non-participating: well baby/child; preventive mammograms. Participating Rx drugs. Vision age 18 and younger - 1st \$150 vision hardware. Participating: vision exam. Non-participating: 1st \$40 vision exam. | This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at www.healthcare.gov/coverage/preventive-care-benefits/ . |
| Are there other <u>deductibles</u> for specific services? | No. | You don't have to meet <u>deductibles</u> for specific services. |
| What is the <u>out-of-pocket limit</u> for this <u>plan</u>? | Participating <u>provider</u> : \$7,350 person/\$14,700 family Non-participating <u>provider</u> : \$14,700 person/\$29,400 family | The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met. |
| What is not included in the <u>out-of-pocket limit</u>? | <u>Premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover. | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> . |
| Will you pay less if you use a <u>network provider</u>? | Yes. See http://providerdirectory.PacificSource.com/?nPlan=SmartHealth+(Montana+Members) or call 1-877-590-1596 for a list of <u>network providers</u> . | This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services. |
| Do you need a <u>referral</u> to see a <u>specialist</u>? | No. | You can see the <u>specialist</u> you choose without a <u>referral</u> . |

 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 |
|---|--|---|---|---|
| | | Participating Provider (You will pay the least) | Non-participating Provider (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 | \$20 <u>co-pay</u> /visit, <u>deductible</u> does not apply | <u>Deductible</u> then 25% <u>co-insurance</u> | None |
| | <u>Specialist</u> visit | \$50 <u>co-pay</u> /visit, <u>deductible</u> does not apply | <u>Deductible</u> then 25% <u>co-insurance</u> | None |
| | <u>Preventive care/screening/immunization</u> | No charge, <u>deductible</u> does not apply | <u>Deductible</u> then 25% <u>co-insurance</u> Preventive mammograms: No charge, <u>deductible</u> does not apply Well baby/child: 25% <u>co-insurance</u> , <u>deductible</u> does not apply Tobacco Cessation: Not covered | Preventive Physicals: 1 hospital visit at birth, as recommended by child's pediatrician ages 0-7, annually ages 8 and older. Well Woman Visits: annually. You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for. |
| If you have a test | <u>Diagnostic test</u> (x-ray, blood work) | <u>Deductible</u> then 30% <u>co-insurance</u> | <u>Deductible</u> then 55% <u>co-insurance</u> | None |
| | Imaging (CT/PET scans, MRIs) | <u>Deductible</u> then 30% <u>co-insurance</u> | <u>Deductible</u> then 55% <u>co-insurance</u> | <u>Preauthorization</u> required. |
| If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at http://PacificSource.com/drug-list/MT/ . | Tier one drugs | Retail: \$15 <u>co-pay</u> /per prescription, <u>deductible</u> does not apply Mail: \$30 <u>co-pay</u> /per prescription, <u>deductible</u> does not apply | <u>Deductible</u> then 50% <u>co-insurance</u> | Retail limited to 30 day supply. Mail limited to 90 day supply. <u>Preauthorization</u> required for certain drugs. |
| | Tier two drugs | Retail: \$60 <u>co-pay</u> /per prescription, <u>deductible</u> does not apply Mail: \$180 <u>co-pay</u> /per prescription, <u>deductible</u> does not apply | <u>Deductible</u> then 50% <u>co-insurance</u> | |
| | Tier three drugs | Retail: \$100 <u>co-pay</u> /per prescription, <u>deductible</u> does not apply | <u>Deductible</u> then 50% <u>co-insurance</u> | |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|--|--|--|--|
| | | Participating Provider (You will pay the least) | Non-participating Provider (You will pay the most) | |
| | | Mail: \$300 <u>co-pay</u> /per prescription, <u>deductible</u> does not apply | | |
| | Tier four <u>specialty drugs</u> | \$250 <u>co-pay</u> /per prescription, <u>deductible</u> does not apply | <u>Deductible</u> then 50% <u>co-insurance</u> | Participating <u>provider</u> benefit available only through our specialty pharmacy services <u>provider</u> . Limited to 30 day supply. <u>Preauthorization</u> required for certain drugs. |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | <u>Deductible</u> then 30% <u>co-insurance</u> | <u>Deductible</u> then 55% <u>co-insurance</u> | None |
| | Physician/surgeon fees | <u>Deductible</u> then 30% <u>co-insurance</u> | <u>Deductible</u> then 55% <u>co-insurance</u> | |
| If you need immediate medical attention | Emergency room services | Medical Emergency: <u>Deductible</u> then \$250 <u>co-pay</u> /visit plus 30% <u>co-insurance</u> Non-Emergency: <u>Deductible</u> then \$250 <u>co-pay</u> /visit plus 30% <u>co-insurance</u> | Medical Emergency: <u>Deductible</u> then \$250 <u>co-pay</u> /visit plus 30% <u>co-insurance</u> Non-Emergency: <u>Deductible</u> then \$250 <u>co-pay</u> /visit plus 55% <u>co-insurance</u> | <u>Co-pay</u> waived if admitted. |
| | <u>Emergency medical transportation</u> | Ground: <u>Deductible</u> then 30% <u>co-insurance</u> Air: <u>Deductible</u> then 30% <u>co-insurance</u> | Ground: <u>Deductible</u> then 30% <u>co-insurance</u> Air: <u>Deductible</u> then 30% <u>co-insurance</u> | Limited to nearest facility able to treat condition. Air covered if ground medically or physically inappropriate. Non-participating air based on 200 percent of Medicare allowance, except as required by law. |
| | <u>Urgent care</u> | \$20 <u>co-pay</u> /visit, <u>deductible</u> does not apply | <u>Deductible</u> then 25% <u>co-insurance</u> | None |
| If you have a hospital stay | Facility fee (e.g., hospital room) | <u>Deductible</u> then 30% <u>co-insurance</u> | <u>Deductible</u> then 55% <u>co-insurance</u> | Limited to semi-private room unless intensive or coronary care units, <u>medically necessary</u> isolation, or hospital only has private rooms. <u>Preauthorization</u> required for some inpatient services. |
| | Physician/surgeon fees | <u>Deductible</u> then 30% <u>co-insurance</u> | <u>Deductible</u> then 55% <u>co-insurance</u> | None |
| If you need mental health, behavioral | Outpatient services | \$20 <u>co-pay</u> /visit, <u>deductible</u> does not apply | <u>Deductible</u> then 25% <u>co-insurance</u> | None |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|--|
| | | Participating Provider (You will pay the least) | Non-participating Provider (You will pay the most) | |
| health, or substance abuse services | Inpatient services | <u>Deductible</u> then 30% <u>co-insurance</u> | <u>Deductible</u> then 55% <u>co-insurance</u> | <u>Preauthorization</u> required for some inpatient services. |
| If you are pregnant | Office visits | <u>Deductible</u> then 30% <u>co-insurance</u> | <u>Deductible</u> then 55% <u>co-insurance</u> | <u>Cost sharing</u> does not apply to certain <u>preventive services</u> . 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. |
| | Childbirth/delivery professional services | | | |
| | Childbirth/delivery facility services | | | |
| If you need help recovering or have other special health needs | <u>Home health care</u> | <u>Deductible</u> then 30% <u>co-insurance</u> | <u>Deductible</u> then 55% <u>co-insurance</u> | Limited to 180 days/year. No coverage for private duty nursing or custodial care. <u>Preauthorization</u> required. |
| | <u>Rehabilitation services</u> | Inpatient: <u>Deductible</u> then 30% <u>co-insurance</u> Outpatient: <u>Deductible</u> then 30% <u>co-insurance</u> | Inpatient: <u>Deductible</u> then 55% <u>co-insurance</u> Outpatient: <u>Deductible</u> then 55% <u>co-insurance</u> | <u>Preauthorization</u> required. No coverage for recreation therapy. Inpatient: None Outpatient: None |
| | <u>Habilitation services</u> | Inpatient: <u>Deductible</u> then 30% <u>co-insurance</u> Outpatient: <u>Deductible</u> then 30% <u>co-insurance</u> | Inpatient: <u>Deductible</u> then 55% <u>co-insurance</u> Outpatient: <u>Deductible</u> then 55% <u>co-insurance</u> | <u>Preauthorization</u> required. No coverage for recreation therapy. Inpatient: None Outpatient: None |
| | <u>Skilled nursing care</u> | <u>Deductible</u> then 30% <u>co-insurance</u> | <u>Deductible</u> then 55% <u>co-insurance</u> | Limited to 60 days/year. No coverage for custodial care. <u>Preauthorization</u> required. |
| | <u>Durable medical equipment</u> | <u>Deductible</u> then 30% <u>co-insurance</u> | <u>Deductible</u> then 55% <u>co-insurance</u> | Limited to: \$5,000 year overall; one pair/year for glasses or contact lenses; one breast pump/pregnancy; \$150/year for wig for chemotherapy or radiation therapy. <u>Preauthorization</u> required if equipment is over \$1,000 and for power-assisted wheelchairs. |
| | <u>Hospice services</u> | <u>Deductible</u> then 30% <u>co-insurance</u> | <u>Deductible</u> then 55% <u>co-insurance</u> | <u>Preauthorization</u> required. No coverage for private duty nursing. |
| If your child needs dental or eye care | Children's eye exam | No charge, <u>deductible</u> does not apply | No charge up to \$40 maximum, <u>deductible</u> does not apply, then <u>Deductible</u> then 100% <u>co-insurance</u> | For age 18 or younger, one eye exam/year. |

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|----------------------|----------------------------|---|---|--|
| | | Participating Provider (You will pay the least) | Non-participating Provider (You will pay the most) | |
| | Children's glasses | Combined participating and non-participating: No charge up to \$150 maximum, <u>deductible</u> does not apply, then subject to participating <u>providers</u> medical <u>deductible</u> and <u>co-insurance</u> | Combined participating and non-participating: No charge up to \$150 maximum, <u>deductible</u> does not apply, then subject to participating <u>providers</u> medical <u>deductible</u> and <u>co-insurance</u> | Combined participating and non-participating: For age 18 or younger, one pair of glasses (frames and lenses) or contact lenses in lieu of glasses per year. Additional coatings not covered. |
| | Children's dental check-up | Not covered | Not covered | Not covered |

Excluded Services & Other Covered Services:

| Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .) | | |
|--|---|---|
| <ul style="list-style-type: none">• Bariatric surgery• Cosmetic surgery (Except medically necessary or certain reconstructive surgeries)• Custodial care | <ul style="list-style-type: none">• Dental care (Adult)• Dental check-up (Child)• Hearing aids (Child)• Hearing aids (Adult) | <ul style="list-style-type: none">• Long-term care• Non-emergency care when traveling outside the U.S.• Private-duty nursing• Routine foot care, other than with diabetes mellitus |
| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.) | | |
| <ul style="list-style-type: none">• Abortion• Acupuncture | <ul style="list-style-type: none">• Chiropractic care• Infertility treatment (Except for reversal of sterilization and in vitro fertilization) | <ul style="list-style-type: none">• Routine eye care (Adult)• Weight loss programs |

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 Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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 1-877-590-1596 or the Montana Commissioner of Securities and Insurance at 1-800-332-6148 or at csimt.gov. 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.

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 1-877-590-1596.

————— *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 | \$4000 |
| ■ Specialist | \$50 <u>co-payment</u> |
| ■ Hospital (facility) | 30% <u>co-insurance</u> |
| ■ Other | 30% <u>co-insurance</u> |

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:

| <u>Cost Sharing</u> | |
|-----------------------------------|----------------|
| <u>Deductibles</u> | \$3,630 |
| <u>Copayments</u> | \$0 |
| <u>Coinsurance</u> | \$3,720 |
| <u>What isn't covered</u> | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$7,410 |

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

| | |
|--|-------------------------|
| ■ The plan's overall deductible | \$4000 |
| ■ Specialist | \$50 <u>co-payment</u> |
| ■ Hospital (facility) | 30% <u>co-insurance</u> |
| ■ Other | 30% <u>co-insurance</u> |

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:

| <u>Cost Sharing</u> | |
|-----------------------------------|----------------|
| <u>Deductibles</u> | \$915 |
| <u>Copayments</u> | \$1,700 |
| <u>Coinsurance</u> | \$392 |
| <u>What isn't covered</u> | |
| Limits or exclusions | \$55 |
| The total Joe would pay is | \$3,062 |

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

| | |
|--|-------------------------|
| ■ The plan's overall deductible | \$4000 |
| ■ Specialist | \$50 <u>co-payment</u> |
| ■ Hospital (facility) | 30% <u>co-insurance</u> |
| ■ Other | 30% <u>co-insurance</u> |

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 | \$1,925 |
|---------------------------|----------------|

In this example, Mia would pay:

| <u>Cost Sharing</u> | |
|-----------------------------------|----------------|
| <u>Deductibles</u> | \$1,142 |
| <u>Copayments</u> | \$150 |
| <u>Coinsurance</u> | \$490 |
| <u>What isn't covered</u> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$1,782 |