



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/plan-details>. 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 [HealthCare.gov/sbc-glossary](https://www.healthcare.gov/sbc-glossary) or call 1-877-590-1596 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-network provider: \$1,500 individual/\$3,000 family Out-of-network provider: \$3,000 individual/\$6,000 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 deductible?	Yes. In-network: <u>preventive care</u> . Out-of-network: well baby/child care; preventive mammograms. In-network: Rx drugs. Vision age 18 and younger - 1st \$150 vision hardware. In-network: vision exam. Out-of-network: 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 Healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	In-network provider: \$5,000 individual/\$10,000 family Out-of-network provider: \$25,000 individual/\$50,000 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 out-of-pocket limit?	<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 network provider?	Yes. See Providerdirectory.pacificsource.com/?nPlan=Voyager 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 referral to see a specialist?	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.

What You Will Pay				
Common Medical Event	Services You May Need	In-network (You will pay the least)	Out-of-network (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	10% <u>co-insurance</u>	50% <u>co-insurance</u>	None
	<u>Specialist</u> visit	10% <u>co-insurance</u>	50% <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	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. Tobacco cessation: Not covered out-of-network.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	10% <u>co-insurance</u>	50% <u>co-insurance</u>	None
	Imaging (CT/PET scans, MRIs)	10% <u>co-insurance</u>	50% <u>co-insurance</u>	<u>Preauthorization</u> required.
	Tier one drugs	Retail: \$15 <u>co-pay</u> /prescription, <u>deductible</u> does not apply Mail: \$30 <u>co-pay</u> /prescription, <u>deductible</u> does not apply	50% <u>co-insurance</u>	

What You Will Pay

Common Medical Event	Services You May Need	In-network (You will pay the least)	Out-of-network (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at https://pacificsource.com/drug-list	Tier two drugs	Retail: \$50 <u>co-pay</u> /prescription, <u>deductible</u> does not apply Mail: \$150 <u>co-pay</u> /prescription, <u>deductible</u> does not apply	50% <u>co-insurance</u>	Prescription benefit includes certain outpatient drugs as a preventive benefit at no charge when received in-network, <u>deductible</u> does not apply. <u>Cost share</u> amounts shown represent a 30 day supply at retail and a 90 day supply at mail order. Quantity for retail and mail order are limited to a 90 day supply. Quantity for <u>Specialty drug</u> is limited to 30 day supply. <u>Preauthorization</u> required for certain drugs. If a manufacturer coupon or rebate is used, the amount of the discount will not accumulate toward the deductible or the maximum out-of-pocket limit.
	Tier three drugs	Retail: \$75 <u>co-pay</u> /prescription, <u>deductible</u> does not apply Mail: \$225 <u>co-pay</u> /prescription, <u>deductible</u> does not apply	50% <u>co-insurance</u>	
	Tier four drugs	\$250 <u>co-pay</u> /prescription, <u>deductible</u> does not apply	50% <u>co-insurance</u>	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>co-insurance</u>	50% <u>co-insurance</u>	None
	Physician/surgeon fees	10% <u>co-insurance</u>	50% <u>co-insurance</u>	
If you need immediate medical attention	<u>Emergency room care</u>	Medical emergency: 10% <u>co-insurance</u> Non-emergency: 10% <u>co-insurance</u>	Medical emergency: 10% <u>co-insurance</u> Non-emergency: 50% <u>co-insurance</u>	None
	<u>Emergency medical transportation</u>	Ground: 10% <u>co-insurance</u> Air: 10% <u>co-insurance</u>	Ground: 10% <u>co-insurance</u> Air: 10% <u>co-insurance</u>	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, except as required by law.
	<u>Urgent care</u>	10% <u>co-insurance</u>	50% <u>co-insurance</u>	None

What You Will Pay

Common Medical Event	Services You May Need	In-network (You will pay the least)	Out-of-network (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>co-insurance</u>	50% <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	10% <u>co-insurance</u>	50% <u>co-insurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% <u>co-insurance</u>	50% <u>co-insurance</u>	None
	Inpatient services	10% <u>co-insurance</u>	50% <u>co-insurance</u>	<u>Preauthorization</u> required for some inpatient services.
If you are pregnant	Office visits	10% <u>co-insurance</u>	50% <u>co-insurance</u>	<u>Cost sharing</u> does not apply for <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>	10% <u>co-insurance</u>	50% <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: 10% <u>co-insurance</u> Outpatient: 10% <u>co-insurance</u>	Inpatient: 50% <u>co-insurance</u> Outpatient: 50% <u>co-insurance</u>	Inpatient: None. <u>Preauthorization</u> required. Outpatient: None No coverage for recreation therapy.
	<u>Habilitation services</u>	Inpatient: 10% <u>co-insurance</u> Outpatient: 10% <u>co-insurance</u>	Inpatient: 50% <u>co-insurance</u> Outpatient: 50% <u>co-insurance</u>	Inpatient: None. <u>Preauthorization</u> required. Outpatient: None No coverage for recreation therapy.
	<u>Skilled nursing care</u>	10% <u>co-insurance</u>	50% <u>co-insurance</u>	Limited to 60 days/year. No coverage for custodial care.

What You Will Pay

Common Medical Event	Services You May Need	In-network (You will pay the least)	Out-of-network (You will pay the most)	Limitations, Exceptions, & Other Important Information
	<u>Durable medical equipment</u>	10% <u>co-insurance</u>	50% <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>	10% <u>co-insurance</u>	50% <u>co-insurance</u>	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 routine eye exam/year.
	Children's glasses	Combined in-network and out-of-network: 10% <u>co-insurance</u>	Combined in-network and out-of-network: 10% <u>co-insurance</u>	Combined in-network and out-of-network: For age 18 or younger, one pair of glasses (frames and lenses) or contacts (lenses and fitting) in lieu of glasses per year. Additional coatings not covered. No charge up to \$150 maximum, <u>deductible</u> does not apply.
	Children's dental check-up	Not covered	Not covered	Not covered

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.)

- Bariatric surgery
- Cosmetic surgery (Except medically necessary or certain reconstructive surgeries)
- Dental care (Adult)
- Hearing aids (Adult)
- Hearing aids (Child)
- 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

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Abortion
- Acupuncture
- Chiropractic care
- Infertility treatment (Except for reversal of sterilization and in vitro fertilization)
- 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: Montana Commissioner of Securities and Insurance at 1-800-332-6148 or at csimt.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 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.

Does this plan provide Minimum Essential Coverage? Yes.

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? Not Applicable.

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** \$1,500
- **Specialist** 10% co-insurance
- **Hospital (facility)** 10% co-insurance
- **Other** 10% co-insurance

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	\$12,700
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In this example, Peg would pay:

Cost Sharing

<u>Deductibles</u>	\$1500
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$1100

What isn't covered

Limits or exclusions	\$60
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The total Peg would pay is	\$2,670
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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** 10% co-insurance
- **Hospital (facility)** 10% co-insurance
- **Other** 10% co-insurance

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	\$5,600
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In this example, Joe would pay:

Cost Sharing

<u>Deductibles</u>	\$1500
<u>Copayments</u>	\$800
<u>Coinsurance</u>	\$40

What isn't covered

Limits or exclusions	\$20
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The total Joe would pay is	\$2,360
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Mia's Simple Fracture

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

- **The plan's overall deductible** \$1,500
- **Specialist** 10% co-insurance
- **Hospital (facility)** 10% co-insurance
- **Other** 10% co-insurance

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	\$2,800
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In this example, Mia would pay:

Cost Sharing

<u>Deductibles</u>	\$1500
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$100

What isn't covered

Limits or exclusions	\$0
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The total Mia would pay is	\$1,610
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