PacificSource HEALTH PLANS

Medical Outline of Coverage
Navigator HSA 5000_20+Rx S2

Butte Auto LLC

Benefit Year: Calendar Year

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

Provider Network: Navigator

Deductible Per Benefit Year	In-network	Out-of-network
Individual/Family	$5,000/$10,000	$10,000/$20,000
Out-of-Pocket Limit Per Benefit Year	**In-network**	**Out-of-network**
Individual/Family	$6,900/$13,800	$13,800/$27,600

Note: In-network deductible and out-of-pocket limit accumulate separately from the out-of-network deductible and out-of-pocket limit. Even though you may have the same benefit for in-network and out-of-network, your actual costs for services provided out-of-network may exceed this plan's out-of-pocket limit for out-of-network services. In addition, out-of-network providers may in certain situations bill you for the difference between the amount charged by the provider and the amount allowed by the insurance company (called balance billing). Balance billing amounts are not counted toward the out-of-network out-of-pocket limit. For additional information about balance billing or allowable fees, see your handbook.

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. The large group premium changes for the last five years were 2025 6.9%, 2024 8.9%, 2023 7.7%, 2022 4.8%, and 2021 7.2%.

The member is responsible for any amounts shown above, in addition to the following amounts:

Service/Supply	In-network Member Pays	Out-of-network Member Pays
Preventive Care		
Well baby/Well child care	No deductible, 0%	No deductible, 50%
Preventive physicals	No deductible, 0%	No deductible, 50%
Well woman visits	No deductible, 0%	No deductible, 0%
Preventive mammograms	No deductible, 0%	No deductible, 0%
Immunizations	No deductible, 0%	No deductible, 0%
Preventive colonoscopy	No deductible, 0%	After deductible, 50%
Prostate cancer screening	No deductible, 0%	No deductible, 50%

Service/Supply	In-network Member Pays	Out-of-network Member Pays
Professional Services		
Office and home visits	After deductible, 20%	After deductible, 50%
Naturopath office visits	After deductible, 20%	After deductible, 50%
Specialist office and home visits	After deductible, 20%	After deductible, 50%
Telehealth visits	After deductible, 20%	After deductible, 50%
Office procedures and supplies	After deductible, 20%	After deductible, 50%
Surgery	After deductible, 20%	After deductible, 50%
Outpatient rehabilitation services	After deductible, 20%	After deductible, 50%
Chiropractic manipulation/Spinal manipulation and Acupuncture (15 visits per benefit year)	After deductible, 20%	After deductible, 50%
Biofeedback (10 sessions per lifetime)	After deductible, 20%	After deductible, 50%
Cardiac rehabilitation (short term outpatient - 36 visits per lifetime)	After deductible, 20%	After deductible, 50%
Hospital Services		
Inpatient room and board	After deductible, 20%	After deductible, 50%
Inpatient rehabilitation services	After deductible, 20%	After deductible, 50%
Skilled nursing facility care	After deductible, 20%	After deductible, 50%
Outpatient Services		
Outpatient surgery/services	After deductible, 20%	After deductible, 50%
Diagnostic and supplemental breast examinations	After deductible, 0%	After deductible, 50%
Diagnostic imaging – advanced	After deductible, 20%	After deductible, 50%
Diagnostic and therapeutic radiology/laboratory and dialysis – non-advanced	After deductible, 20%	After deductible, 50%
Urgent and Emergency Services		
Urgent care center visits	After deductible, 20%	After deductible, 50%
Emergency room visits – medical emergency	After deductible, 20%	After deductible, 20%

Service/Supply	In-network Member Pays	Out-of-network Member Pays
Emergency room visits – non-emergency	After deductible, 20%	After deductible, 50%
Ambulance, ground	After deductible, 20%	After deductible, 20%
Ambulance, air	After deductible, 20%	After deductible, 20%
Maternity Services		
Physician/Provider services (global charge)	After deductible, 20%	After deductible, 50%
Hospital/Facility services	After deductible, 20%	After deductible, 50%
Mental Health and Substance Use Disorder Services		
Office visits	After deductible, 20%	After deductible, 50%
Inpatient care	After deductible, 20%	After deductible, 50%
Residential programs	After deductible, 20%	After deductible, 50%
Other Covered Services		
Allergy injections	After deductible, 20%	After deductible, 50%
Durable medical equipment	After deductible, 20%	After deductible, 50%
Home health services	After deductible, 20%	After deductible, 50%
Transplants	After deductible, 0%	After deductible, 50%

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

Additional information

What is the 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.

Note that there is a separate category for in-network and out-of-network when it comes to meeting your deductible.

What is the out-of-pocket limit?

The out-of-pocket limit is the most you'll pay for covered services during the benefit year. Once the out-of-pocket limit has been met, the plan will pay 100 percent of allowed amounts for covered services for the rest of that benefit 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 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 in-network and out-of-network when it comes to meeting your out-of-pocket limit.

Payments to providers

Payment to providers is based on the prevailing or allowable fee for covered services. In-network providers accept the allowable fee as payment in full. Services of out-of-network providers could result in out-of-pocket expense in addition to the percentage indicated.

Allowable fee for out-of-network providers

PacificSource's payment to out-of-network providers may be derived from several sources, depending on the service or supply and the service area where it is provided. To calculate our payment to out-of-network providers, we determine the allowable fee, then subtract the out-of-network provider benefits. For more detailed information, please refer to the Out-of-network Providers section of your handbook.

Prior authorization

Coverage of certain medical services and surgical procedures requires a benefit determination by PacificSource before the services are performed. This process is called prior authorization. Prior authorization is necessary to determine if certain services and supplies are covered under this plan, and if you meet the plan's eligibility requirements. Prior authorization does not change your out-of-pocket expense. You can search for procedures and services that require prior authorization on our website, Authgrid.PacificSource.com (select Commercial for the line of business).

Please refer to the Utilization Review and Appeal Procedures sections of your handbook for information about utilization review, adverse determinations, and your rights with respect to those procedures.

Discrimination is against the law

PacificSource Health Plans complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. PacificSource does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The member's right to know the costs of medical procedures

When requested by the member or the member's agent, PacificSource shall provide a summary of the member's coverage for a specific healthcare service or course of treatment when an actual charge or estimate of charges by a provider, outpatient center for surgical services, clinic, or hospital exceeds $500. PacificSource shall make a good faith effort to provide accurate information based on cost estimates and procedure codes obtained by the member from the member's 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.

Emergency medical conditions

For emergency medical conditions, out-of-network providers are paid at the in-network provider level.

Emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition that places the health of the individual in serious jeopardy, would result in serious impairment to bodily functions, or serious dysfunction of any bodily organ or part, or with respect to a pregnant woman having contractions, that there is inadequate time to safely transfer the woman to another hospital for delivery, or that a transfer may pose a threat to the health or safety of the woman or the unborn child.

PacificSource HEALTH PLANS

Prescription Drug Benefit Summary
MT 20P 5000D S2 MDL

Butte Auto LLC

Benefit Year: Calendar Year

Formulary: Montana Drug List (MDL)

This plan includes coverage for prescription drugs and certain other pharmaceuticals, subject to the information below. This plan complies with federal healthcare reform. To check which tier your prescription falls under, call our Customer Service team or visit PacificSource.com/find-a-drug.

The amount you pay for covered prescriptions at in-network pharmacies applies toward your plan's in-network medical out-of-pocket limit, the amount you pay for covered prescriptions at out-of-network pharmacies applies toward your plan's out-of-network out-of-pocket limit which is shown on the Medical Benefit Summary. The copayment and/or coinsurance for prescription drugs obtained from an in-network or out-of-network pharmacy are waived during the remainder of the benefit year in which you have satisfied the medical out-of-pocket limit.

Medical Deductible

You must meet the medical deductible, which is shown on the Medical Benefit Summary, before your prescription drug benefits begin.

PacificSource Expanded (Preventive) No-cost Drug List

Your prescription benefit includes certain outpatient drugs as a preventive benefit at no deductible, $0 copay. This includes specific drugs that are taken regularly to prevent a disease or to keep a specific disease or condition from progressing. You can get a list of covered preventive drugs by contacting our Customer Service team or visit PacificSource.com and select Find a Drug.

Affordable Care Act Standard Preventive No-cost Drug List

Your prescription benefit includes preventive care drugs at no cost to you and are not subject to a deductible or MAC penalties when filled at an in-network pharmacy. This benefit includes some drugs required by the Affordable Care Act, including tobacco cessation drugs. These drugs are identified on the drug list as Tier 0.

Each time a covered prescription is dispensed, you are responsible for any amounts shown above, in addition to the following amounts:

Service/ Supply	Tier 1 Member Pays	Tier 2 Member Pays	Tier 3 Member Pays	Tier 4 Member Pays
In-network Retail Pharmacy				
Up to a 30 day supply:	After deductible, 20%*	After deductible, 20%*	After deductible, 20%*	After deductible, 20%
31 – 60 day supply:	After deductible, 20%	After deductible, 20%	After deductible, 20%	After deductible, 20%
61 – 90 day supply:	After deductible, 20%	After deductible, 20%	After deductible, 20%	After deductible, 20%

Service/ Supply	Tier 1 Member Pays	Tier 2 Member Pays	Tier 3 Member Pays	Tier 4 Member Pays
In-network Mail Order Pharmacy				
Up to a 30 day supply:	After deductible, 20%*	After deductible, 20%*	After deductible, 20%*	After deductible, 20%
31 – 60 day supply:	After deductible, 20%	After deductible, 20%	After deductible, 20%	After deductible, 20%
61 – 90 day supply:	After deductible, 20%	After deductible, 20%	After deductible, 20%	After deductible, 20%
Compound Drugs**				
Up to a 30 day supply:	After deductible, 20%			
31 – 60 day supply:	After deductible, 20%			
61 – 90 day supply:	After deductible, 20%			
Out-of-network Pharmacy				
30 day maximum fill, no more than three fills allowed per year:	After deductible, 90%			

*Formulary prescription insulin is not subject to a deductible and is limited to $35 copay per 30 day supply when filled at an in-network pharmacy.

**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 medications are on the applicable formulary.

Specialty Medications must be filled through an in-network specialty pharmacy and are limited to a 30 day supply.

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 copayment and/or coinsurance plus the difference in cost between the brand name drug and its generic equivalent after the medical 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 copayment and/or coinsurance after the medical deductible is met. The cost difference between the brand name and generic drug does not apply toward the medical deductible or out-of-pocket limit.

If your provider prescribes a non-formulary drug due to medical necessity it may be subject to exception review.

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