PacificSource HEALTH PLANS

Belgrade School District

# Outline of Coverage
# Voyager HSA 6500+Rx S3

Provider Network: **Voyager**

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

| Deductible Per Contract Year | In-network and Out-of-network |
|---|---|
| **Individual/Family** | $6,500/$13,000 |
| **Out-of-Pocket Limit Per Contract Year** | **In-network and Out-of-network** |
| **Individual/Family** | $6,500/$13,000 |

**Note:** Your actual costs for services provided by an out-of-network provider may exceed this policy's out-of-pocket limit for out-of-network services. In addition, out-of-network providers can bill you for the difference between the amount charged by the provider and the amount allowed by the insurance company, and this amount is not counted toward the out-of-network out-of-pocket limit. Please see allowable fee in the Definitions section of your member 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 increases for the last five years were 2019 0.1%, 2018 9.6%, 2017 7.4%, 2016 15.0%, and 2015 4.6%.

## 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, 0% |
| **Preventive physicals** | No deductible, 0% | No deductible, 0% |
| **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, 0% |
| **Prostate cancer screening** | No deductible, 0% | No deductible, 0% |
| **Professional Services** | | |
| **Office and home visits** | After deductible, 0% | After deductible, 0% |
| **Naturopath office visits** | After deductible, 0% | After deductible, 0% |
| **Specialist office and home visits** | After deductible, 0% | After deductible, 0% |
| **Telemedicine visits** | After deductible, 0% | After deductible, 0% |
| **Office procedures and supplies** | After deductible, 0% | After deductible, 0% |

| Service/Supply | In-network Member Pays | Out-of-network Member Pays |
|---|---|---|
| **Surgery** | After deductible, 0% | After deductible, 0% |
| **Outpatient rehabilitation services** | After deductible, 0% | After deductible, 0% |
| **Chiropractic manipulations and acupuncture (Chiro: 15 visits per benefit year. Acupuncture: 15 visits per benefit year.)** | After deductible, 0% | After deductible, 0% |
| **Hospital Services** | | |
| **Inpatient room and board** | After deductible, 0% | After deductible, 0% |
| **Inpatient rehabilitation services** | After deductible, 0% | After deductible, 0% |
| **Skilled nursing facility care** | After deductible, 0% | After deductible, 0% |
| **Outpatient Services** | | |
| **Outpatient surgery/services** | After deductible, 0% | After deductible, 0% |
| **Advanced diagnostic imaging** | After deductible, 0% | After deductible, 0% |
| **Diagnostic and therapeutic radiology/lab** | After deductible, 0% | After deductible, 0% |
| **Urgent and Emergency Services** | | |
| **Urgent care center visits** | After deductible, 0% | After deductible, 0% |
| **Emergency room visits – medical emergency** | After deductible, 0% | After deductible, 0% |
| **Emergency room visits – non-emergency** | After deductible, 0% | After deductible, 0% |
| **Ambulance, ground** | After deductible, 0% | After deductible, 0% |
| **Ambulance, air** | After deductible, 0% | After deductible, 0%+ |
| **Maternity Services** | | |
| **Physician/Provider services (global charge)** | After deductible, 0% | After deductible, 0% |
| **Hospital/Facility services** | After deductible, 0% | After deductible, 0% |
| **Mental Health and Substance Use Disorder Services** | | |
| **Office visits** | After deductible, 0% | After deductible, 0% |
| **Inpatient care** | After deductible, 0% | After deductible, 0% |
| **Residential programs** | After deductible, 0% | After deductible, 0% |
| **Other Covered Services** | | |
| **Allergy injections** | After deductible, 0% | After deductible, 0% |
| **Durable medical equipment** | After deductible, 0% | After deductible, 0% |
| **Home health services** | After deductible, 0% | After deductible, 0% |
| **Transplants** | After deductible, 0% | After deductible, 0% |
| **Infertility** | After deductible, 0% | After deductible, 0% |

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

+ Out-of-network air ambulance coverage is covered at 200 percent of the Medicare allowance, except as required by law. You may be held responsible for the amount billed in excess. Please see your member handbook for additional information or contact our Customer Service team with questions.

# 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. Deductible expense is applied to the out-of-pocket limit.

In-network provider expense and out-of-network provider expense apply together toward your deductible.

## What is the out-of-pocket limit?

The out-of-pocket limit is the most you'll pay for covered medical expenses during the plan 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 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 member 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.

In-network provider expense and out-of-network provider expense apply together toward your out-of-pocket limit.

## Payments to providers

Payment to providers is based on the prevailing or contracted PacificSource fee allowance for covered services. In-network providers accept the fee allowance as payment in full. Out-of-network providers are allowed to balance bill any remaining balance that your plan did not cover. 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

Outside the PacificSource service area and in areas where our members do not have reasonable access to an in-network provider through one of our third party provider networks, the allowable fee, depending upon the service and supply, will be based on the use of the UCR or the in-network provider contracted rate, whichever is greater. For more detailed information, please refer to the Out-of-network Providers section of your member handbook.

## Preauthorization

Coverage of certain medical services and surgical procedures requires a benefit determination by PacificSource before the services are performed. This process is called preauthorization. Preauthorization is necessary to determine if certain services and supplies are covered under this plan, and if you meet the plan's eligibility requirements. Preauthorization does not change your out-of-pocket expense for in-network and out-of-network providers. You'll find the most current preauthorization list on our website, PacificSource.com/member/preauthorization.aspx.

## The patient's right to know the costs of medical procedures

The insured, or the insured's agent, may request an estimate of the member's portion of provider charges for any service or course of treatment that exceeds $500. PacificSource shall make a good faith effort to provide accurate information based on cost estimates and procedure codes obtained by

the insured from the insured's healthcare 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 6500D S2 MDL

**Formulary:** Montana Drug List (MDL)

This PacificSource health 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/drug-list.

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

## Medical Plan Deductible

You must meet the medical plan deductibles, which are shown on the Medical Benefit Summary, before your prescription drug benefits begin for Tier one, Tier two, Tier three, compound, and Tier four prescription drugs.

## PacificSource Expanded No Cost Drug List

Your prescription benefit includes certain outpatient drugs as a preventive benefit at no deductible, $0. This includes specific drugs that are taken regularly to prevent a disease or to keep a specific disease or condition from progressing. Preventive drugs are taken to help avoid many illnesses and conditions. You can get a list of covered preventive drugs by contacting our Customer Service team or visit PacificSource.com/drug-list to view the PacificSource Expanded No Cost Drug List.

## Each time a covered prescription is dispensed, you are responsible for the amounts below:

| 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 90 day supply:** | After deductible, 0% | After deductible, 0% | After deductible, 0% | After deductible, 0% |
| **In-network Mail Order Pharmacy** | | | | |
| **Up to a 90 day supply:** | After deductible, 0% | After deductible, 0% | After deductible, 0% | After deductible, 0% |
| **Compound Drugs**** | | | | |
| **Up to a 90 day supply:** | After deductible, 0% | | | |
| **Out-of-network Pharmacy** | | | | |
| **30 day max fill, no more than three fills allowed per year:** | After deductible, 0% | | | |

^Remember to show your PacificSource member ID card each time you fill a prescription at a retail pharmacy. If your ID card is not used, your benefits cannot be applied and may result in higher out-of-pocket cost.

**Compounded medications are subject to a preauthorization 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 co-payment and/or co-insurance 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 co-payment and/or co-insurance after the medical deductible is met. The cost difference between the brand name and generic drug does not apply toward the medical plan's deductible or out-of-pocket limit.

If your provider prescribes a non-formulary drug due to medical necessity it may be subject to preauthorization for coverage at no charge.

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