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, visit www.mcebp.com or call 406-258-4876 option 1. 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 at https://www.healthcare.gov/SBC-GLOSSARY or call 406-258-4876 option 1 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$500** person / **$1,000** family. Does not apply to certain Preventive care and prescription drugs.	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 plan document to see when the **deductible** starts over. See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there services covered before you meet your deductible?	Yes. Preventive care and outpatient counseling sessions for chemical dependency and mental health is covered before you meet your **deductible**.	This **plan** covers some items and services even if you have not met the **deductible** amount, but a **copayment** or **coinsurance** may apply. For example, this **plan** covers certain **preventive services** without **cost-sharing** and before you meet your **deductible**. See a list of covered preventive services at http://www.healthcare.gov/coverage/preventive-care-benefits.
Are there other deductibles for specific services?	Yes, **$150** person / **$300** family for prescription drug costs. There is no other specific deductible.	You must pay all the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	**Medical: $4,000** person / **$8,000** family. **Prescription**: **$2,600** person / **$5,200** family.	The **out-of-pocket limit** is the most you could pay in a year for covered services. If you have other family members in this plan, they must meet their own out-of-pocket limit until the overall family **out-of-pocket limit** has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, and health care that plan does not cover.	Even though you pay these expenses, they do not count toward the **out-of-pocket limit**.
Will you pay less if you use a network provider?	Yes. See www.mcebp.com or call 406-258-4876 option 1 for a list of network providers.	If you use an in-network provider or other health care **provider**, this plan will pay some or all 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 for different kinds of **providers**.
Do you need a referral to	A referral is required for physical,	This plan will pay some or all the costs to see a **specialist** for covered services. A referral is

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Important Questions	Answers	Why This Matters:
see a specialist?	speech and occupational therapy.	required for coverage for physical, speech, and occupational therapy.

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
		Network Provider (You will pay the least)	Out-of-Network 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	30% coinsurance	50% coinsurance	
	Specialist visit	30% coinsurance	50% coinsurance	Not covered without referral: includes physical, speech and occupational therapy.
	Preventive care/screening/ immunization	No charge	30% coinsurance	Must be a listed preventive service benefit of the Affordable Care Act.
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance	50% coinsurance	
	Imaging (CT/PET scans, MRIs)	30% coinsurance	50% coinsurance	Supplemental breast imaging, including ultrasounds and MRI's for individuals 40 and older deemed high risk (other factors apply), fall under Preventive benefits.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.medimpact.com.	Generic drugs (Tier 1)	15% coinsurance with a $20 co-pay maximum – Retail 30 15% coinsurance with a $40 co-pay maximum – Retail 90 and Mail Order		Not covered without a drug card. Mail Order no deductible. Generic mandatory. Opiates not covered without a preauthorization. Members are required to participate in cost-savings programs, coupon programs or financial assistance programs.
	Preferred brand drugs (Tier 2)	30% coinsurance with a $50 co-pay maximum – Retail 30 30% coinsurance with a $100 co-pay maximum – Retail 90 and Mail Order		
	Non-preferred brand drugs (Tier 3)	40% coinsurance with a $150 co-pay maximum – Retail 30 40% coinsurance with a $300 co-pay maximum – Retail 90 and Mail Order		
	Specialty drugs	40% coinsurance with a $300 co-pay maximum		Preauthorization required. Covers up to a

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				30-day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	50% coinsurance	A second opinion may be required.
	Physician/surgeon fees	30% coinsurance	50% coinsurance	
If you need immediate medical attention	Emergency room care	30% coinsurance	30% coinsurance	Out of Network: 30% coinsurance for services protected under the No Surprises Act. 45 CFR Part 149.
	Emergency medical transportation	30% coinsurance	50% coinsurance	Out of Network: 30% coinsurance for services protected under the No Surprises Act. 45 CFR Part 149.
	Urgent care	30% coinsurance	50% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	50% coinsurance	Not covered without preauthorization.
	Physician/surgeon fees	30% coinsurance	50% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	30% coinsurance *Deductible Waived	30% coinsurance *Deductible Waived	Substance use disorder outpatient services not covered for court-ordered or employer-mandated services.
	Inpatient services	30% coinsurance	30% coinsurance	Not covered without preauthorization.
If you are pregnant	Office visits	30% coinsurance	50% coinsurance	Only covered for employee or a covered spouse or domestic partner of the employee.
	Childbirth/delivery professional services	30% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	30% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	30% coinsurance	50% coinsurance	Not covered without preauthorization.
	Rehabilitation services	30% coinsurance	50% coinsurance	Not covered without preauthorization.
	Habilitation services	30% coinsurance	50% coinsurance	Some services may require preauthorization and physician referral.
	Skilled nursing care	30% coinsurance	50% coinsurance	Not covered without preauthorization.

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Durable medical equipment	30% coinsurance	50% coinsurance	
	Hospice services	30% coinsurance	50% coinsurance	Not covered without preauthorization.
If your child needs dental or eye care	Children's eye exam	Not covered		
	Children's glasses	Not covered		
	Children's dental check-up	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
- Dental Care (adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine Foot Care

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

- Acupuncture
- Chiropractic care
- Hearing aids
- 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 http://www.dol.gov/ebsa/healthreform. Department of Health and Human Services at 1-877-267-2323 X 61565 or www.cciio.cms.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 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 on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance: Address a written appeal to the Plan Administrator, 200 West Broadway, Missoula, MT 59802-4292. If you have any questions, call 406-523-4876.

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 the 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.

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Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 406-523-4876.Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 406-523-4876.
Chinese (中文): 如果需要中文的帮助， 请拨打这个号码 406-523-4876.Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 406-523-4876

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	$500
Specialist *[cost sharing]*	30%
Hospital (facility) *[cost sharing]*	30%
Other *[cost sharing]*	30%

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**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$0
Coinsurance	$3,500
What is not covered	
Limits or exclusions	$60
Total Example Cost	**$12,700**
The total Peg would pay is	**$4,060**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$500
Specialist *[cost sharing]*	30%
Hospital (facility) *[cost sharing]*	30%
Other *[cost sharing]*	30%

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	**$7,500**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$500
Copayments	$0
Coinsurance	$2,094
Total Example Cost	**$7,500**
What is not covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,614**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$500
Specialist *[cost sharing]*	30%
Hospital (facility) *[cost sharing]*	30%
Other *[cost sharing]*	30%

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	**$2,000**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500

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Total Example Cost	$2,000
Copayments	$0

Total Example Cost	$2,000
Coinsurance	$450

Total Example Cost	$2,000
The total Mia would pay is	**$950**

The plan would be responsible for the other costs of these EXAMPLE covered services.

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