Missoula County Employee Benefits Plan: Standard

Coverage for: Employee + Dependents | **Plan Type:** PPO

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, www.mcebp.com or by calling 406-523-4876. 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 costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy plan documents 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 is covered before you meet your **deductible**.	This **plan** covers some items and services even if you haven't yet 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 **https://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 of 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. Rx **$2,600** person / **$5,200** family.	The **out-of-pocket limits** the most you could pay during a coverage period (usually one year) for your share of the costs of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, and health care this plan does not cover.	Even if you pay these expenses, they don't count toward the **out-of-pocket limit.**
Will you pay less if you use a network provider?	Yes. For a list of network providers, see www.mcebp.com or call 406-258-4876 option 1.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of 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 see a specialist?	Yes. Physical, speech, and occupational therapy.	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist**.

* For more information about limitations and exceptions, see the plan or policy document at www.mcebp.com or call 406-258-4876 option 1.

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	30% coinsurance	
	Specialist visit	30% coinsurance	30% coinsurance	Not covered without preauthorization includes sleep apnea equipment – physical, speech, and occupational therapy.
	Preventive care/screening/ immunization	No charge	30% coinsurance	Must be a listed preventive services benefit of Affordable Care Act.
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance	30% coinsurance	
	Imaging (CT/PET scans, MRIs)	30% coinsurance	30% coinsurance	
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 drug card. Mail-order no deductible. Generic mandatory. Opiates not covered without preauthorization.
	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 $150 co-pay maximum– Retail 90 and Mail Order		
	Specialty drugs (Tier 4)	40% coinsurance with a $300 co-pay maximum		Preauthorization required. Covers up to a 30 day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	30% coinsurance	A second opinion may be required.
	Physician/surgeon fees	30% coinsurance	30% coinsurance	
If you need immediate medical attention	Emergency room care	30% coinsurance	30% coinsurance	
	Emergency medical transportation	30% coinsurance	30% coinsurance	
	Urgent care	30% coinsurance	30% coinsurance	

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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 have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	30% coinsurance	Not covered without pre-certification.
	Physician/surgeon fees	30% coinsurance	30% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	30% coinsurance	30% coinsurance	Substance use disorder outpatient services not covered for court ordered or employer-mandated services.
	Inpatient services	30% coinsurance	30% coinsurance	Not covered without pre-certification.
If you are pregnant	Office visits	30% coinsurance	30% coinsurance	
	Childbirth/delivery professional services	30% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	30% coinsurance	30% coinsurance	
If you need help recovering or have other special health needs	Home health care	30% coinsurance	30% coinsurance	Not covered without pre-certification.
	Rehabilitation services	30% coinsurance	30% coinsurance	Not covered without pre-certification. Physical Therapy is limited to 21 visits per diagnosis.
	Habilitation services	Not covered	Not covered	
	Skilled nursing care	30% coinsurance	30% coinsurance	Not covered without pre-certification.
	Durable medical equipment	30% coinsurance	30% coinsurance	Not covered for sleep apnea without preauthorization.
	Hospice services	30% coinsurance	30% coinsurance	Not covered without pre-certification.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	

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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
- Private-duty Nursing
- Routine Eye Care (Adult)
- Routine Foot Care
- Non-emergency care when traveling outside US

Other Covered Services (Limitations may apply to these services. This isn't 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: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 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 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: Address a written appeal to the Plan Administrator, 200 West Broadway, Missoula, MT 59802-4292. If you have any questions, call us at 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.

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.

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	$500
■ Specialist coinsurance	30%
■ Hospital (facility) coinsurance	30%
■ Other coinsurance	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	**$12,731**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$531
Copayments	$0
Coinsurance	$3,785
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,376**

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 coinsurance	30%
■ Hospital coinsurance	30%
■ Other coinsurance	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	**$7,389**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$650
Copayments	$0
Coinsurance	$2,054
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$2,759**

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

■ The plan's overall deductible	$500
■ Specialist coinsurance	30%
■ Hospital (facility) coinsurance	30%
■ Other coinsurance	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	**$1,925**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$0
Coinsurance	$578
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,078**

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