

**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.missoulacounty.us/government/administration/risk-benefits](http://www.missoulacounty.us/government/administration/risk-benefits) 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 [www.cciio.gov](http://www.cciio.gov) or call 406-523-4876 to request a copy.

| Important Questions   | Answers  | Why This Matters:  |
|---|--|--|
| What is the overall <a href="#">deductible</a> ?                                | <b>\$500</b> person/ <b>\$1,000</b> family.<br>Does not apply to certain Preventive care and prescription drugs.   | You must pay all costs up to the <b>deductible</b> amount before this plan begins to pay for covered services you use. Check your policy plan documents to see when the <b>deductible</b> starts over. See the chart starting on page 2 for how much you pay for covered services after you meet the <b>deductible</b> .   |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | Yes. Preventive care is covered before you meet your <b>deductible</b> .   | This <b>plan</b> covers some items and services even if you haven't yet met the <b>deductible</b> amount. But a <b>copayment</b> or <b>coinsurance</b> may apply. For example, this <b>plan</b> covers certain <b>preventive services</b> without <b>cost sharing</b> and before you meet your <b>deductible</b> . See a list of covered <b>preventive services</b> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> . |
| Are there other <a href="#">deductibles</a> for specific services?              | Yes. <b>\$150</b> person/ <b>\$300</b> family for prescription drug costs. There is no other specific <b>deductible</b> .  | You must pay all of the costs for these services up to the specific <b>deductible</b> amount before this plan begins to pay for these services.  |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | Medical <b>\$4,000</b> person / <b>\$8,000</b> family. Rx <b>\$2,600</b> person / <b>\$5,200</b> family.   | The <b>out-of-pocket limits</b> 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 <a href="#">out-of-pocket limit</a> ?               | Premiums, balance-billed charges, and health care this plan does not cover.  | Even if you pay these expenses, they don't count toward the <b>out-of-pocket limit</b> .   |
| Will you pay less if you use a <a href="#">network provider</a> ?               | Yes. For a list of network providers, see <a href="http://www.missoulacounty.us/government/administration/risk-benefits">www.missoulacounty.us/government/administration/risk-benefits</a> or call 406-523-4876. | If you use an in-network doctor or other health care <b>provider</b> , 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 <b>provider</b> for some services. Plans use the term in-network, <b>preferred</b> , or participating for <b>providers</b> in their <b>network</b> . See the chart starting on page 2 for how this plan pays for different kinds of <b>providers</b> .  |
| Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?    | Yes. Physical, speech, and occupational therapy.   | This plan will pay some or all of the costs to see a <b>specialist</b> for covered services but only if you have the plan's permission before you see the <b>specialist</b> .  |

\* For more information about limitations and exceptions, see the plan or policy document at [www.missoulacounty.us/government/administration/risk-benefits](http://www.missoulacounty.us/government/administration/risk-benefits) or call 406-523-4876.

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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<br>(You will pay the least)  | Out-of-Network Provider<br>(You will pay the most) |   |
| If you visit a health care <a href="#">provider's</a> office or clinic   | Primary care visit to treat an injury or illness       | 30% coinsurance   | 30% coinsurance                                    |   |
|  | <a href="#">Specialist</a> visit                       | 30% coinsurance   | 30% coinsurance                                    | Not covered without preauthorization includes sleep apnea equipment – physical, speech, and occupational therapy.         |
|  | <a href="#">Preventive care/screening/immunization</a> | No charge   | 30% coinsurance                                    | Must be a listed preventive services benefit of Affordable Care Act.  |
| If you have a test   | <a href="#">Diagnostic test</a> (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<br>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.medimpact.com">www.medimpact.com</a> | Generic drugs (Tier 1)                                 | 15% coinsurance with a \$20 co-pay maximum – Retail 30<br>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<br>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<br>40% coinsurance with a \$150 co-pay maximum– Retail 90 and Mail Order |  |   |
|  | <a href="#">Specialty drugs</a> (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  | <a href="#">Emergency room care</a>                    | 30% coinsurance   | 30% coinsurance                                    |   |
|  | <a href="#">Emergency medical transportation</a>       | 30% coinsurance   | 30% coinsurance                                    |   |
|  | <a href="#">Urgent care</a>                            | 30% coinsurance   | 30% coinsurance                                    |   |

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|--|---|--|--|---|
|  |   | Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |   |
| <b>If you have a hospital stay</b>   | Facility fee (e.g., hospital room)        | 30% coinsurance                              | 30% coinsurance                                    | Not covered without pre-certification.  |
|  | Physician/surgeon fees                    | 30% coinsurance                              | 30% coinsurance                                    |   |
| <b>If you need mental health, behavioral health, or substance abuse services</b> | 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.  |
| <b>If you are pregnant</b>   | Office visits                             | 30% coinsurance                              | 30% coinsurance                                    |   |
|  | Childbirth/delivery professional services | 30% coinsurance                              | 30% coinsurance                                    |   |
|  | Childbirth/delivery facility services     | 30% coinsurance                              | 30% coinsurance                                    |   |
| <b>If you need help recovering or have other special health needs</b>            | <a href="#">Home health care</a>          | 30% coinsurance                              | 30% coinsurance                                    | Not covered without pre-certification.  |
|  | <a href="#">Rehabilitation services</a>   | 30% coinsurance                              | 30% coinsurance                                    | Not covered without pre-certification. Physical Therapy is limited to 21 visits per benefit year.       |
|  | <a href="#">Habilitation services</a>     | Not covered                                  | Not covered  |   |
|  | <a href="#">Skilled nursing care</a>      | 30% coinsurance                              | 30% coinsurance                                    | Not covered without pre-certification.  |
|  | <a href="#">Durable medical equipment</a> | 30% coinsurance                              | 30% coinsurance                                    | Not covered for sleep apnea without preauthorization.   |
|  | <a href="#">Hospice services</a>          | 30% coinsurance                              | 30% coinsurance                                    | Not covered without pre-certification.  |
| <b>If your child needs dental or eye care</b>                                    | 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   | • Infertility Treatment | • Routine Eye Care (Adult) |
| • Cosmetic Surgery    | • Long-term Care        | • Routine Foot Care        |
| • Dental Care (Adult) | • Private-duty Nursing  | • Weight Loss Programs     |

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

- |                     |                |  |
|---------------------|----------------|--|
| • Acupuncture       | • Hearing aids | • Non-emergency care when traveling outside the U.S. |
| • Chiropractic Care |                |  |

**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](http://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](http://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](http://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**

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

### 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, kwijigo 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*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,731</b> |
|---------------------------|-----------------|

In this example, Peg would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| Deductibles                       | \$531          |
| Copayments                        | \$0            |
| Coinsurance                       | \$3,785        |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$4,376</b> |

**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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$7,389</b> |
|---------------------------|----------------|

In this example, Joe would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| Deductibles                       | \$650          |
| Copayments                        | \$0            |
| Coinsurance                       | \$2,054        |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$55           |
| <b>The total Joe would pay is</b> | <b>\$2,759</b> |

**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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$1,925</b> |
|---------------------------|----------------|

In this example, Mia would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| Deductibles                       | \$500          |
| Copayments                        | \$0            |
| Coinsurance                       | \$578          |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$1,078</b> |