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, call 1-866-401-3883. 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 1-866-487-2365 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**LOW OPTION Exclusive providers: Single coverage:** $1,500 per person **Family coverage:** $3,000 per family unit **Non-Exclusive providers:** Not covered **HIGH OPTION Exclusive providers: Single coverage:** $2,600 per person **Family coverage:** $5,200 per family unit **Non-Exclusive providers:** Not covered	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. The following Exclusive provider services: routine preventive care, Health Risk Screenings; and preventive maintenance medications are 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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**LOW AND HIGH OPTIONS: Exclusive providers:** **Single coverage:** $5,000 per person **Family coverage:** $10,000 per family unit (and will not exceed $6,550 per any one individual with family coverage and only when using an Exclusive provider); **Non-Exclusive providers: Not covered**	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 have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket	Premiums, balance-billing charges (unless balanced billing is prohibited), amounts over the allowable charge, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.

limit?		
Will you pay less if you use a network provider?	Yes. For a list of **Exclusive providers in the ChoiceCare Provider Network (through Billings Clinic)**, see www.ebms.com or call 1-866-401-3883.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral**.**

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

NOTE: The "70/30" Coinsurance Option has been used as the example in reflecting "What You Will Pay" column for purposes of this Summary of Benefits and Coverage.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Exclusive Provider (You will pay the least)	Non-Exclusive 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	Not covered	None
	Specialist visit	30% coinsurance	Not covered	
	Preventive care/screening/ immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance	Not covered	None
	Imaging (CT/PET scans, MRIs)	30% coinsurance	Not covered	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.ebms.com	**Preventive maintenance medications:** Generic drugs	$15 copayment/ prescription, deductible waived (retail pharmacy); $15 copayment/ prescription, deductible waived (mail order pharmacy)	Not covered	The medical deductible does not apply to preventive maintenance medications. Coverage is limited to a 30-day supply (retail pharmacy) and up to a 90-day supply (mail order pharmacy). For more information regarding pharmacy benefit coverage, contact Navitus Customer Care toll free at 1 (866) 333-2757.
	Brand Name drugs – Formulary	$45 copayment/ prescription, deductible waived (retail pharmacy); $90 copayment/ prescription, deductible waived (mail order pharmacy)	Not covered	
	Brand Name drugs – Non-Formulary	35% coinsurance/ prescription, deductible waived (retail pharmacy or mail order pharmacy)	Not covered	
	Generic drugs	$15 copayment/ prescription (retail pharmacy);	Not covered	Prescription drugs (other than preventive maintenance medications) will be payable

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Exclusive Provider (You will pay the least)	Non-Exclusive Provider (You will pay the most)	
		$15 copayment/ prescription (mail order pharmacy)		after the medical deductible. Coverage is limited to a 30-day supply (retail pharmacy) and up to a 90-day supply (mail order pharmacy). For more information regarding pharmacy benefit coverage, contact Navitus Customer Care toll free at 1 (866) 333-2757.
	Brand Name drugs – Formulary	$45 copayment/ prescription (retail pharmacy); $90 copayment/ prescription (mail order pharmacy)	Not covered	
	Brand Name drugs – Non-Formulary	35% coinsurance/ prescription (retail pharmacy or mail order pharmacy)	Not covered	
	Specialty drugs	30% coinsurance / Prescription	Not covered	Specialty drug medications will be payable after the medical deductible. Specialty drugs must be purchased through the *mi*Rx Specialty Pharmacy. For more information call (406) 869-6551 or toll-free at 1 (866) 894-1496.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	Not covered	None
	Physician/surgeon fees	30% coinsurance	Not covered	None
If you need immediate medical attention	Emergency room care Medical Emergency	30% coinsurance		Services for Medical Non-Emergency Care will be payable at the 70th percentile of the allowable charge and only when provided by an Exclusive provider.
	Medical Non-Emergency Care	30% coinsurance	Not covered	
	Emergency medical transportation	30% coinsurance		Services for a medical non-emergency transport will be payable at the 70th percentile of the allowable charge and will be payable at the Exclusive provider coinsurance level.
	Urgent care	30% coinsurance	Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	Not covered	Coverage is limited to the facility's average semi-private room rate.
	Physician/surgeon fees	30% coinsurance	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Exclusive Provider (You will pay the least)	Non-Exclusive Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	30% coinsurance	Not covered	None
	Office visits	30% coinsurance	Not covered	None
	Inpatient services	30% coinsurance	Not covered	None
If you are pregnant	Office visits	30% coinsurance	Not covered	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (e.g. ultrasound).
	Childbirth/delivery professional services	30% coinsurance	Not covered	
	Childbirth/delivery facility services	30% coinsurance	Not covered	Coverage is limited to the facility's average semi-private room rate.
If you need help recovering or have other special health needs	Home health care	30% coinsurance	Not covered	Coverage is limited to 40 visits maximum per calendar year.
	Rehabilitation services	30% coinsurance	Not covered	**Outpatient rehabilitation therapy,** including physical, occupational and speech therapy, is limited to 30 combined visits maximum per calendar year. **Inpatient rehabilitation therapy** is limited to 30 days maximum per calendar year.
	Habilitation services	30% coinsurance	Not covered	
	Skilled nursing care	30% coinsurance	Not covered	Coverage limited to the facility's average semi-private room rate. Coverage limited to 90 days maximum per calendar year.
	Durable medical equipment	30% coinsurance	Not covered	None
	Hospice services	30% coinsurance	Not covered	None
If your child needs dental or eye care	Children's eye exam	No routine vision coverage		None
	Children's glasses	No routine vision coverage		None
	Children's dental check-up	No routine dental coverage		Dental coverage is optional and requires a separate premium amount and separate enrollment election.

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)
- Hearing aids
- Infertility treatment
- Long term care
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

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

- Acupuncture and Chiropractic care (limited to $500 combined benefit maximum per calendar year)

* For more information about limitations and exceptions, see the plan or policy document at www.ebms.com.

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: For group health coverage subject to ERISA, contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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, contact: For group health coverage subject to ERISA, contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program may help with your appeal. A list of states with Consumer Assistance Programs is available at: www.dol.gov/ebsa/healthcarereform and http://www.cms.gov/CCIIO/Resources/Consumer-Assistance -Grants/.

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 1-866-401-3883.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-401-3883.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-866-401-3883.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-401-3883.

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**	**$1,500**
■ **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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$0
Coinsurance	$3,500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,060**

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ **The plan's overall deductible**	**$1,500**
■ **Specialist coinsurance**	**30%**
■ **Hospital (facility) 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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$1,500
Copayments	$1,050
Coinsurance	$880
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$3,485**

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ **The plan's overall deductible**	**$1,500**
■ **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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$0
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,900**

*** Note: The "70/30" Coinsurance Option and a Single Coverage Low Option ($1,500 Exclusive provider deductible) has been used to calculate these Coverage Examples for the purposes of this Summary of Benefits and Coverage document.**

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