




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 or visit www.ebms.com. 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:
<p>What is the overall deductible?</p>	<p>LOW OPTION Exclusive providers: Single coverage: \$1,500 per person Family coverage: \$3,000 per family unit Non-Exclusive providers: Not covered</p> <p>HIGH OPTION Exclusive providers: Single coverage: \$2,600 per person Family coverage: \$5,200 per family unit Non-Exclusive providers: Not covered</p>	<p>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.</p>
<p>Are there services covered before you meet your deductible?</p>	<p>Yes. The following Exclusive provider services: routine preventive care, Health Risk Screenings; and preventive maintenance medications are covered before you meet your deductible.</p>	<p>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/.</p>
<p>Are there other deductibles for specific services?</p>	<p>No.</p>	<p>You don't have to meet deductibles for specific services.</p>
<p>What is the out-of-pocket limit for this plan?</p>	<p>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</p>	<p>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.</p>
<p>What is not included in the out-of-pocket limit?</p>	<p>Premiums, balance-billing charges (unless balanced billing is prohibited), amounts over the allowable charge, and health care this plan doesn't cover.</p>	<p>Even though you pay these expenses, they don't count toward the out-of-pocket limit.</p>

<p>Will you pay less if you use a network provider?</p>	<p>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.</p>	<p>This <u>plan</u> uses a provider <u>network</u>. You will pay less if you use a <u>provider</u> in the <u>plan's network</u>. You will pay the most if you use an <u>out-of-network provider</u>, and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.</p>
<p>Do you need a referral to see a specialist?</p>	<p>No.</p>	<p>You can see the <u>specialist</u> you choose without a <u>referral</u>.</p>

 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	

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 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 <u>copayment</u> / prescription, <u>deductible</u> waived (retail pharmacy); \$15 <u>copayment</u> / prescription, <u>deductible</u> waived (mail order pharmacy)	Not covered	The medical <u>deductible</u> 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 <u>copayment</u> / prescription, <u>deductible</u> waived (retail pharmacy); \$90 <u>copayment</u> / prescription, <u>deductible</u> waived (mail order pharmacy)	Not covered	
	Brand Name drugs – Non-Formulary	35% <u>coinsurance</u> / prescription, <u>deductible</u> waived (retail pharmacy or mail order pharmacy)	Not covered	
	Generic drugs	\$15 <u>copayment</u> / prescription (retail pharmacy); \$15 <u>copayment</u> / prescription (mail order pharmacy)	Not covered	<u>Prescription drugs</u> (other than preventive maintenance medications) will be payable after the medical <u>deductible</u> .
	Brand Name drugs – Formulary	\$45 <u>copayment</u> / prescription (retail pharmacy); \$90 <u>copayment</u> / prescription (mail order pharmacy)	Not covered	Coverage is limited to a 30-day supply (retail pharmacy) and up to a 90-day supply (mail order pharmacy).
	Brand Name drugs – Non-Formulary	35% <u>coinsurance</u> / prescription (retail pharmacy or mail order pharmacy)	Not covered	For more information regarding pharmacy benefit coverage, contact Navitus Customer Care toll free at 1 (866) 333-2757.
	<u>Specialty drugs</u>	30% <u>coinsurance</u> / Prescription	Not covered	<u>Specialty drug</u> medications will be payable after the medical <u>deductible</u> . <u>Specialty drugs</u> must be purchased through the <i>miRx</i> Specialty Pharmacy. For more information call (406) 869-6551 or toll-free at 1 (866) 894-1496.

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% <u>coinsurance</u>	Not covered	None
	Physician/surgeon fees	30% <u>coinsurance</u>	Not covered	None
If you need immediate medical attention	<u>Emergency room care</u> Medical Emergency	30% <u>coinsurance</u>		Services for Medical Non-Emergency Care will be payable at the 70 th percentile of the allowable charge and only when provided by an Exclusive <u>provider</u> .
	Medical Non-Emergency Care	30% <u>coinsurance</u>	Not covered	
	<u>Emergency medical transportation</u>	30% <u>coinsurance</u>		Services for a medical non-emergency transport will be payable at the 70 th percentile of the allowable charge and will be payable at the Exclusive <u>provider coinsurance</u> level.
	<u>Urgent care</u>	30% <u>coinsurance</u>	Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	30% <u>coinsurance</u>	Not covered	Coverage is limited to the facility's average semi-private room rate.
	Physician/surgeon fees	30% <u>coinsurance</u>	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	30% <u>coinsurance</u>	Not covered	None
	Office visits	30% <u>coinsurance</u>	Not covered	None
	Inpatient services	30% <u>coinsurance</u>	Not covered	None
If you are pregnant	Office visits	30% <u>coinsurance</u>	Not covered	<u>Cost sharing</u> does not apply to certain <u>preventive services</u> . Depending on the type of services, <u>coinsurance</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (e.g. ultrasound).
	Childbirth/delivery professional services	30% <u>coinsurance</u>	Not covered	
	Childbirth/delivery facility services	30% <u>coinsurance</u>	Not covered	Coverage is limited to the facility's average semi-private room rate.

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 help recovering or have other special health needs	<u>Home health care</u>	30% <u>coinsurance</u>	Not covered	Coverage is limited to 40 visits maximum per calendar year.
	<u>Rehabilitation services</u>	30% <u>coinsurance</u>	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.
	<u>Habilitation services</u>	30% <u>coinsurance</u>	Not covered	
	<u>Skilled nursing care</u>	30% <u>coinsurance</u>	Not covered	
	<u>Durable medical equipment</u>	30% <u>coinsurance</u>	Not covered	None
	<u>Hospice services</u>	30% <u>coinsurance</u>	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](#).)

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|-----------------------|--|----------------------------|
| • Bariatric surgery | • Infertility treatment | • Private duty nursing |
| • Cosmetic surgery | • Long term care | • Routine eye care (Adult) |
| • Dental care (Adult) | • Non-emergency care when traveling outside the U.S. | • Routine foot care |
| • Hearing aids | | • 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)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. For more information, contact the **COBRA Administrator, 1-406-248-6178**, or these agencies: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/agencies/ebsa/ or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, 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: EBMS at 1-800-777-3575 or the DOL's Employee Benefits Security Administration at 1-866-444-EBSA (3272). Additionally, a consumer assistance program can help you file your appeal. Contact your state's program if available at: <http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/>.

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 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, kwijigo 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	\$12,800
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles*	\$1,500
Copayments	\$0
Coinsurance	\$3,500
<i>What isn't covered</i>	
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
- [Primary care physician 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	\$7,400
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles*	\$1,500
Copayments	\$1,050
Coinsurance	\$880
<i>What isn't covered</i>	
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	\$1,900
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles*	\$1,500
Copayments	\$0
Coinsurance	\$400
<i>What isn't covered</i>	
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.