



Employee Benefits - City of Kalispell Custom Plan Summary

Effective 7/1/20 - This Document is a summary of coverage only. The MMIA Employee Benefits Program Plan Documents are available at www.mmiaeb.net and must be referenced for details of all coverages.

| Kalispell Custom Plan | |
|--|---|
| Deductible (Individual/Family) (January 1 - December 31) | \$1,000 / \$2,000 |
| Benefit Percentage (what the Plan pays if the Deductible is waived or after the Deductible is met) | |
| • All Montana Providers and Non-Montana Cigna Providers | 70% |
| • Non-Montana, Non-Cigna Providers | 50% |
| Annual Out-of-Pocket Maximum (the most you will pay for covered services in a plan year) Individual/Family | \$3,000 / \$6,000 |
| Medical Services | |
| Preventive care as recommended by the US Preventive Services Task Force, CDC, and Health Resources & Services Administration at www.healthcare.gov | 100% Plan paid |
| Professional Provider Services - including primary care, therapies (physical, occupational, speech, cardiac, and rehabilitation), and chemical dependency treatment | \$25 Copay, Deductible waived |
| Urgent Care | \$50 Copay, Deductible waived |
| Emergency Room | \$100 Copay, Deductible waived |
| Alternative Medicine Benefit – Plan pays up to \$500 after Copays | \$25 Copay, Deductible waived |
| Mental Health, Newborn Care, Surgical Services | |
| • Professional Provider | 100% Plan paid |
| • Facility Provider | Deductible waived, Plan pays 70% |
| Maternity and Diagnostic | |
| • Professional Provider | 100% Plan paid |
| • Facility Provider | Deductible applies, then Plan pays 70% |
| Diabetic Education | |
| Hospice Care | |
| Anesthesia Services | 100% Plan paid |
| Nutritional Counseling - up to 10 visits per year | |
| Durable Medical Equipment | |
| Home Health Care | Deductible waived, Plan pays 70% |
| Hospital Professional Provider | |
| • Outpatient | \$25 Copay |
| • Inpatient | 100% Plan paid |
| Hospital Facility Services | |
| Obesity Surgery - one per lifetime, up to \$30,000 | Deductible applies, then Plan pays 70% |
| Medical Supplies for use outside of Facility | |
| Prescription Drug Benefit - Copay Plan | |
| Deductible per Benefit Period (separate from medical) | \$300 per Covered Person |
| Generic | \$10 Copay Retail / \$20 Copay Mail Order |
| Brand Formulary | \$20 Copay Retail / \$40 Copay Mail Order |
| Brand Non-Formulary | \$40 Copay Retail / \$80 Copay Mail Order |

Plan Cost

| | | | |
|-------------------------------|----------|--|----------|
| Employee Only | \$ 717 | Medicare Retiree Only | \$ 466 |
| Employee & Spouse | \$ 1,434 | Medicare Retiree & Medicare Spouse | \$ 932 |
| Employee & Child(ren) | \$ 1,255 | One with Medicare & One without Medicare | \$ 1,183 |
| Employee, Spouse & Child(ren) | \$ 1,972 | | |