Coverage for: Single/Family| Plan Type: Indemnity

The Summary of Benefits and Coverage (SBC) shows you how you and the plan would share the cost for covered health care services. This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the Plan Document and Summary Plan Description at www.abpmtpa.com/mcahct or by calling 1-877-720-7827. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary included with this SBC.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$ 575 person/calendar yr $1150 family/calendar yr	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your Plan Document and Summary Plan Description to see when the deductible starts over (January 1). See the chart 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?	Pre-admission tests, first $300 of Accident (within 90 days of the Accident), Birthing Centers, Generic Drugs, Wellness	
Are there other deductibles for specific services?	There are no other specific deductibles.	
What is the out-of-pocket limit for this plan?	$4,025 person/calendar yr $11,500 family/calendar yr	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. Includes deductible and co-insurance.
What is not included in the out-of-pocket limit?	Co-payments, Premiums, balance-billed charges and care this plan does not cover.	Even though 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, in most cases you will pay less if you use a network provider.	
Do you need a referral to see a specialist?	No, you do not need a referral to see a specialist.	You can see the specialist you choose without permission from this plan.

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	20% Coinsurance	20% Coinsurance	None, subject to Maximum Eligible Expense
	Specialist visit	20% Coinsurance	20% Coinsurance	None, subject to Maximum Eligible Expense
	Preventive care/screening/ immunization	No Charge	No Charge	None, subject to Maximum Eligible Expense
If you have a test	Diagnostic test (x-ray, blood work)	20% Coinsurance	20% Coinsurance	None, subject to Maximum Eligible Expense
	Imaging (CT/PET scans, MRIs)	20% Coinsurance	20% Coinsurance	None, subject to Maximum Eligible Expense
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.abpmtpa.com/mcahct/	Generic drugs	No Charge	No Charge	No Deductible. Coverage is limited to a 90-day supply FDA approved prescription.
	Preferred brand drugs	20% Coinsurance per Prescription Retail & Mail	20% Coinsurance per Prescription Retail & Mail	Deductible applies. Coverage is limited to a 90-day supply FDA approved prescription.
	Non-preferred brand drugs	20% Coinsurance per Prescription Retail & Mail	20% Coinsurance per Prescription Retail & Mail	Deductible applies. Coverage is limited to a 90-day supply FDA approved prescription.
	Specialty drugs	20% Coinsurance per Prescription Retail & Mail	20% Coinsurance per Prescription Retail & Mail	Deductible applies. Coverage is limited to a 90-day supply FDA approved prescription.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance	20% Coinsurance	Subject to Medically Necessary, Medical Policy & Maximum Eligible Expense
	Physician/surgeon fees	20% Coinsurance	20% Coinsurance	Subject to Medically Necessary, Medical Policy & Maximum Eligible Expense
If you need immediate medical attention	Emergency room care	20% Coinsurance	20% Coinsurance	None, subject to Maximum Eligible Expense
	Emergency medical transportation	20% Coinsurance	20% Coinsurance	None, subject to Maximum Eligible Expense
	Urgent care	20% Coinsurance	20% Coinsurance	None, subject to Maximum Eligible Expense
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Coinsurance	20% Coinsurance	None, subject to Maximum Eligible Expense- Inpatient admission notification recommended. Call 1-800-342-6510
	Physician/surgeon fees	20% Coinsurance	20% Coinsurance	None, subject to Maximum Eligible Expense

[* For more information about limitations and exceptions, see the plan or policy document at www.abpmtpa.com/mcahct.

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 need mental health, behavioral health, or substance abuse services	Outpatient services	20% Coinsurance	20% Coinsurance	None, subject to Maximum Eligible Expense
	Inpatient services	20% Coinsurance	20% Coinsurance	None, subject to Maximum Eligible Expense-Inpatient admission notification recommended. Call 1-800-342-6510
If you are pregnant	Office visits	20% Coinsurance	20% Coinsurance	None, subject to Maximum Eligible Expense
	Childbirth/delivery professional services	20% Coinsurance	20% Coinsurance	None, subject to Maximum Eligible Expense
	Childbirth/delivery facility services	20% Coinsurance	20% Coinsurance	None, subject to Maximum Eligible Expense
If you need help recovering or have other special health needs	Home health care	No charge	No Charge	Coverage limited to 120 visits/calendar year, subject to Maximum Eligible Expense
	Rehabilitation services	20% Coinsurance	20% Coinsurance	None, subject to Maximum Eligible Expense
	Habilitation services	20% Coinsurance	20% Coinsurance	None, subject to Maximum Eligible Expense
	Skilled nursing care	No charge first 10 days following hospital stay	No charge first 10 days following hospital stay	Coverage after 10 days is subject to 20% Coinsurance and limited to 60 days per Convalescent Period. All coverage subject to Maximum Eligible Expense
	Durable medical equipment	20% Coinsurance	20% Coinsurance	None, subject to Maximum Eligible Expense
	Hospice services	20% Coinsurance	20% Coinsurance	Coverage limited to $10,000 per Hospice Benefit Period
If your child needs dental or eye care	Children's eye exam	No charge	No charge	2 exams per Calendar Year
	Children's glasses	No charge	No charge	1 set lenses & frames per Calendar Year
	Children's dental check-up	No charge	No charge	None

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
- Infertility Treatment
- Long-term care
- Non-emergency care when traveling outside the U.S. for the purpose of obtaining treatment, services, drugs or supplies
- Private-duty nursing
- 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 if it is prescribed by a physician
- Chiropractic care
- Dental Care (Adult)

[* For more information about limitations and exceptions, see the plan or policy document at www.abpmtpa.com/mcahct.

- Hearing Aids
- Routine eye care (Adult)

Your Rights to Continue Coverage: Contact the plan at 1-877-720-7827. There are also agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Office of the Commissioner of Securities & Insurance, 840 Helena Ave, Helena, MT 59601 (800) 332-6148 (in-state only) https://www.csi.mt.gov; the US Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa or the US Department of Health and Human Services at 1-877-267-2323 x 61565 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 information about your rights, this notice, or assistance, contact: 1-877-720-7827 or visit us at www.abpmtpa.com/mcahct . You may also contact the US Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program, can help you file your appeal. Contact the Office of the Commissioner of Securities & Insurance, 840 Helena Ave Helena, MT 59601 (800)332-6148 (in-state only) http://www.csi.mt.gov.

Does this plan provide Minimum Essential Coverage? Yes, this plan does provide Minimum Essential Coverage.
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, this plan does meet the Minimum Value Standard for the benefits it provides.
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.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

[* For more information about limitations and exceptions, see the plan or policy document at www.abpmtpa.com/mcahct.

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	$575
Specialist *[coinsurance]*	20%
Hospital (facility) *[coinsurance]*	20%
Other *[coinsurance]*	20%

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)	$ 198
Childbirth/Delivery Professional Services	$2,394
Childbirth/Delivery Facility Services	$8,959
Diagnostic tests (*ultrasounds and blood work*)	$1,046
Specialist visit (*anesthesia*)	$ 0
Prescription Drugs: Generic	$ 36
Over-the-Counter Drugs	$ 60
Preventive Services & Vaccines	$ 37
Total Example Cost	**$12,730**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$575
Copayments	$0
Coinsurance	$2404
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,039**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$575
Specialist *[coinsurance]*	20%
Hospital (facility) *[coinsurance]*	20%
Other *[coinsurance]*	20%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)	$ 791
Professional Services: Specialist	$ 273
Diagnostic tests (*blood work*)	$ 134
Prescription drugs: Generic	$ 676
Prescription drugs: Branded	$ 3,582
Over-the-counter Drugs	$ 55
Preventive Services & Vaccines	$ 150
Durable medical equipment (*glucose meter*)	$1,728
Total Example Cost	**$7,389**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$575
Copayments	$0
Coinsurance	$1,187
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$1,817**

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

The plan's overall deductible	$575
Specialist *[coinsurance]*	20%
Hospital (facility) *[coinsurance]*	20%
Other *[coinsurance]*	20%

This EXAMPLE event includes services like:

Ambulance	$ 593
Professional Services: Specialist	$ 293
Emergency room care (*including medical supplies*)	$ 594
Diagnostic test (*x-ray*)	$ 30
Durable medical equipment (*crutches*)	$ 199
Rehabilitation services (*physical therapy*)	$ 216
Total Example Cost	**$1,925**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$575
Copayments	$0
Coinsurance	$210
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$785**

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

Language Access Services: The information below is a requirement of Section 1557 of the Affordable Care Act effective August 18, 2016. It is required to assist those who may need assistance with the English language or translation assistance to a different language in which they are more fluent.

لاو ملصا فـتاهبكم: 1-855-999-1062 (مقر . 1063-999-855) مقبر صلتا .نجاملبا لك فراوتتديقوغللا ةعدساملا تامدخنإف ،ةغللا ركذا ثدحتتنتكا اذإ :ةظوحلم

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-999-1062（TTY：1-855-999-1063)

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-855-999-1062 (TTY: 1-855-999-1063).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-855-999-1062 (TTY: 1-855-999-1063).

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-999-1062 (ATS: 1-855-999-1063).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-999-1062 (TTY: 1-855-999-1063).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-999-1062 (TTY: 1-855-999-1063).

注意事項：**日本語を話される場合、無料の言語支援をご利用いただけま**.1-855-999-1062（TTY:1-855-999-1063）**まで、お電話にてご連絡ください**.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-999-1062 (TTY: 1-855-999-1063) 번으로 전화해 주십시오.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-855-999-1062 (TTY: 1-855-999-1063).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-855-999-1062 (TTY: 1-855-999-1063).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-999-1062 (телетайп: 1-855-999-1063).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-999-1062 (TTY: 1-855-999-1063).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-999-1062 (TTY: 1-855-999-1063).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-999-1062 (TTY: 1-855-999-1063).