



## Employee Benefits - City of Kalispell Custom Plan Summary

Effective 7/1/22 - This Document is a summary of coverage only. The MMIA Employee Benefits Program Plan Documents are available at [www.mmiaeb.net](http://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%
<b>Annual Out-of-Pocket Maximum</b> (the most you will pay for covered services in a plan year) Individual/Family	\$3,000 / \$6,000
<b>Medical Services</b>	
Preventive care as recommended by the US Preventive Services Task Force, CDC, and Health Resources & Services Administration at <a href="http://www.healthcare.gov">www.healthcare.gov</a>	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 applies, then Plan pays 70%
Maternity and Diagnostic	
• Professional Provider	100% Plan-paid
• Facility Provider	Deductible waived, 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	
<b>Prescription Drug Benefit</b>	
<b>Deductible per Benefit Period (separate from medical)</b>	\$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