



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, go to www.mountainhealth.coop or call 1-844-262-1560. 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 www.healthcare.gov/sbc-glossary.com or call 1-800-318-2596 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	For network providers : \$3,000 individual \$6,000 family; For out-of-network providers : \$6,000 individual \$12,000 family	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 plan , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible .
Are there services covered before you meet your deductible ?	Yes. Preventive care services 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 ?	For network providers : \$5,800 individual \$11,600 family; For out-of-network providers : \$11,600 individual \$23,200 family	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 limit ?	Copayments on certain services, premiums , balance-billing charges, and health care this plan doesn't 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. See www.mountainhealth.coop/find-a-doctor or call 1-855 447-2900 for information regarding network providers .	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.

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	30% coinsurance	50% coinsurance	None
	Specialist visit	30% coinsurance	50% coinsurance	None
	Preventive care/screening/immunization	No Charge	50% coinsurance	You may have to pay for services that are not preventive. Ask your provider if the services needed are preventive, then check what your plan will pay for. Frequency limits may apply.
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance	50% coinsurance	This benefit does not include diagnostic services such as biopsies, which are services that are routinely covered under the Surgical Services Benefit.
	Imaging (CT/PET scans, MRIs)	30% coinsurance	50% coinsurance	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at https://www.mountainhealth.coop/pharmacy	Generic drugs	30% coinsurance	50% coinsurance	30-day supply retail 90-day supply mail-order.
	Preferred brand drugs	30% coinsurance	50% coinsurance	30-day supply retail 90-day supply mail-order. If you choose a higher Tier drug when lower Tier drug is available, you must pay an ancillary charge in addition to the deductible and/or coinsurance, as applicable.
	Non-preferred brand drugs	30% coinsurance	50% coinsurance	30-day supply retail 90-day supply mail-order. If you choose a higher Tier drug when a lower Tier drug is available, you must pay an ancillary charge in addition to the deductible and/or coinsurance, as applicable.
	Specialty drugs	30% coinsurance	N/A	30-day supply Mail order not available. In-Network coverage limited to select pharmacies.

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	50% coinsurance	None
	Physician/surgeon fees	30% coinsurance	50% coinsurance	None
If you need immediate medical attention	Emergency room care	\$100 Copay + 30% coinsurance	\$100 Copay + 30% coinsurance	None
	Emergency medical transportation	30% coinsurance	30% coinsurance	None
	Urgent care	30% coinsurance	50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	50% coinsurance	None
	Physician/surgeon fees	30% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	30% coinsurance	50% coinsurance	None
	Inpatient services	30% coinsurance	50% coinsurance	None
If you are pregnant	Office visits	Included in delivery	Included in delivery	None
	Childbirth/delivery professional services	30% coinsurance	50% coinsurance	None
	Childbirth/delivery facility services	30% coinsurance	50% coinsurance	None
If you need help recovering or have other special health needs	Home health care	30% coinsurance	50% coinsurance	180 visit / year
	Rehabilitation services	30% coinsurance	50% coinsurance	20 visits combined for physical, occupational, and speech therapy
	Habilitation services	30% coinsurance	50% coinsurance	20 visits combined for physical, occupational, and speech therapy
	Skilled nursing care	30% coinsurance	50% coinsurance	30 days / year
	Durable medical equipment	30% coinsurance	50% coinsurance	See policy documents.
	Hospice services	30% coinsurance	50% coinsurance	None
If your child needs hearing aids, dental care or eye care	Children's eye exam	No Charge	25% coinsurance	Coverage is limited to one Vision Examination per Covered Dependent Child under age 19, per Calendar Year.

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)	
	Children's glasses	No Charge	25% coinsurance	Coverage is limited to one frame per Covered Dependent Child under age 19, per Calendar Year.
	Children's dental check-up	Not Covered	Not Covered	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 .)		
• Abortion (except in the case of rape, incest, or when the life of the mother is endangered) • Bariatric Surgery • Dental Care • Hearing Aids • Infertility Treatment •	• Long Term Care • Non-emergency care when traveling outside the United States. • Private-duty nursing unless the hospital does not have an urgent care or acute care unit. • Religious counseling • Reversal of an elective sterilization	• Self-help programs • Temporomandibular joint dysfunction • Transplants of non-human/artificial organs • Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture (Up to 12 visits/year) • Chiropractic care (Up to 20 visits/year) • Cosmetic surgery (Only if medically necessary or for certain reconstructive surgeries)	• Dental Care up to \$100 limit, paid through reimbursement • Routine eye care (adult) up to \$60 limit, paid through reimbursement	• Non-emergency care when traveling outside the United States. See www.mhc.coop • Routine foot care provided to a member with Diabetes

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: Mountain Health CO-OP at 1-844-262-1560, State insurance department contact information at 1-866-444-3272 or <https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa> State consumer assistance program at <http://www.cms.gov/ccio/Resources/Consumer-Assistance-Grants>, Office of Personnel Management Multi State Plan Program at <https://www.opm.gov/healthcare-insurance/multi-state-plan-program/externalreview/> 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

* For more information about limitations and exceptions, see the [plan](#) or policy document at <https://www.mountainhealth.coop>

[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: www.mhc.coop or call 1-844-262-1560.

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](#).

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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	\$4,400
■ Specialist cost sharing	0%
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	0%

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:	
<i>Cost Sharing</i>	
Deductibles	\$4,400
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$4,460

Managing Joe's Type 2 Diabetes

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

■ The plan's overall deductible	\$4,400
■ Specialist cost sharing	0%
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	0%

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:	
<i>Cost Sharing</i>	
Deductibles	\$4,400
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$4,420

Mia's Simple Fracture

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

■ The plan's overall deductible	\$4,400
■ Specialist cost sharing	0%
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	0%

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:	
<i>Cost Sharing</i>	
Deductibles	\$2,800
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$2,800

