




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.mhc.coop](http://www.mhc.coop) or call 1-844-22-150. 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 1-800-318-259 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	For <a href="#">network providers</a> : <b>\$3,000</b> individual / <b>\$6,000</b> family; for <a href="#">out-of-network providers</a> : <b>\$6,000</b> individual / <b>\$12,000</b> family	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> and primary care services are covered before you meet your <a href="#">deductible</a>	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No	You don't have to meet deductibles for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	For <a href="#">network providers</a> : <b>\$6,000</b> individual / <b>\$12,000</b> family; for <a href="#">out-of-network providers</a> : <b>\$12,000</b> individual / <b>\$24,000</b> family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Copayments</a> on certain services, <a href="#">premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.mhc.coop">www.mhc.coop</a> or call <b>(855) 447-2900</b> for information regarding <a href="#">network providers</a>	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 Most [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)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visits to treat an injury or illness	\$40 <a href="#">copay</a> /office visit and 30% <a href="#">coinsurance</a> after <a href="#">deductible</a> for other outpatient services	70% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None
	<a href="#">Specialist</a> visit	\$60 <a href="#">copay</a> /office visit and 30% <a href="#">coinsurance</a> after <a href="#">deductible</a> for other outpatient services	70% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None
	<a href="#">Preventive care/screening/immunization</a>	No charge	70% <a href="#">coinsurance</a> after <a href="#">deductible</a>	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your provider if the services needed are preventive. Then check what your <a href="#">plan</a> pays for.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	70% <a href="#">coinsurance</a> after <a href="#">deductible</a>	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% <a href="#">coinsurance</a> after <a href="#">deductible</a>	70% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.mhc.coop/Idaho/explore-plans/drug-list/">www.mhc.coop/Idaho/explore-plans/drug-list/</a>	Tier 1-Preferred Generic drugs	\$10 <a href="#">copay</a> per drug /script for 31-day retail order \$20 <a href="#">copay</a> per drug /script 90-day mail order	\$10 <a href="#">copay</a> per drug /script for 31-day retail order \$20 <a href="#">copay</a> per drug /script 90-day mail order	None
	Tier 2-Preferred brand and non-preferred Generic drugs	\$40 <a href="#">copay</a> per drug /script for 31-day retail order \$80 <a href="#">copay</a> per drug /script 90-day mail order	\$40 <a href="#">copay</a> per drug /script for 31-day retail order \$80 <a href="#">copay</a> per drug /script 90-day mail order	None
	Tier 3-Non-preferred brand drugs	\$75 <a href="#">copay</a> per drug /script for 31-day retail order \$150 copay	\$75 <a href="#">copay</a> per drug /script for 31-day retail order \$150 copay per	

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)	
		per drug/script for 90 day mail order	drug/script for 90 mail order	
	<a href="#">Specialty drugs</a> Tier 4-Preferred <a href="#">Specialty drugs</a>	\$150 copay per drug/script for 31-day retail order - 90-day mail order not available	\$150 copay per drug/script for 31-day retail order - 90-day mail order not available	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	70% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None
	Physician/surgeon fees	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	70% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None
If you need immediate medical attention	<a href="#">Emergency room care</a>	30% Coinsurance after Deductible	\$100 copay/visit, + 70% Coinsurance after Deductible	None
	<a href="#">Emergency medical transportation</a>	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	70% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None
	<a href="#">Urgent care</a>	\$50 <a href="#">copay</a> per visit	70% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	70% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None
	Physician/surgeon fees	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	70% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None

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)	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient Services Mental/Behavioral health Substance use disorder	\$40 copay/visit, 30% coinsurance after deductible for facility and other services	70% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None
	Inpatient services Mental/Behavioral health Substance use disorder	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	70% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None
<b>If you are pregnant</b>	Office visits - Prenatal and postnatal care	30% <a href="#">coinsurance</a> after <a href="#">deductible</a> for other outpatient services	70% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None
	Childbirth/delivery professional services	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	70% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None
	Childbirth/delivery facility services	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	70% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	70% <a href="#">coinsurance</a> after <a href="#">deductible</a>	30 visit limit/year
	<a href="#">Rehabilitation services</a>	\$60 copay	70% <a href="#">coinsurance</a> after <a href="#">deductible</a>	30 visit limit/year for PT, OT, and ST combined
	<a href="#">Habilitation services</a>	\$60 copay	70% <a href="#">coinsurance</a> after <a href="#">deductible</a>	30 visit limit/year for PT, OT, and ST combined
	<a href="#">Skilled nursing care</a>	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	70% <a href="#">coinsurance</a> after <a href="#">deductible</a>	30 day limit/year
	<a href="#">Durable medical equipment</a>	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	70% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Preauthorization is required for original purchase or replacement of Durable Medical Equipment over \$500
	<a href="#">Hospice services</a>	No Charge. Deductible does not apply	70% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None

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 your child needs dental or eye care	Children’s eye exam	No charge	Not covered	Coverage is limited to one Vision Examination per Insured Dependent Child per Calendar Year.
	Children’s glasses	No charge	Not covered	Coverage is limited to one frame per Insured Dependent Child per Calendar Year.
	Children’s dental check-up	Not covered	Not covered	None

**Excluded Services & Other Covered Services:**

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>• Abortion (except in the case of rape, incest, or when the life of the mother is endangered)</li> <li>• Acupuncture</li> <li>• Bariatric surgery</li> <li>• Dental care and treatment</li> <li>• Infertility treatment</li> </ul>	<ul style="list-style-type: none"> <li>• Long-term care</li> <li>• Marriage counseling</li> <li>• Private-duty nursing</li> <li>• Religious counseling</li> <li>• Reversal of an elective sterilization</li> <li>• Rolfing therapy</li> <li>• Routine eye care (Adult)</li> </ul>	<ul style="list-style-type: none"> <li>• Routine foot care</li> <li>• Self-help programs</li> <li>• Stress management</li> <li>• Temporomandibular joint dysfunction</li> <li>• Transplants of non-human/artificial organs</li> <li>• Weight loss programs</li> </ul>
Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your <a href="#">plan</a> document.)		
<ul style="list-style-type: none"> <li>• Chiropractic care (Up to 20 visits/year)</li> <li>• Hearing Aids (Child Only)</li> </ul>	<ul style="list-style-type: none"> <li>• Cosmetic surgery (Only if medically necessary or for certain reconstructive surgeries)</li> </ul>	<ul style="list-style-type: none"> <li>• Non-emergency care when traveling outside the United States. See <a href="http://www.mhc.coop">www.mhc.coop</a></li> </ul>

**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: [www.YourHealthIdaho.org](http://www.YourHealthIdaho.org) or call 1-855-944-324. 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.YourHealthIdaho.org](http://www.YourHealthIdaho.org) or call 1-855-944-324.

**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: Idaho Department of Insurance 1-800-721-3272.

**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 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](#).

**Language Access Services:**

- Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Mountain Health CO-OP, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 855-447-2900.
- 如果您，或是您正在協助的對象，有關於[插入 項目的名稱 Mountain Health CO-OP, 方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 [在此插入數字 855-447-2900。
- Ukoliko Vi ili neko kome Vi pomažete ima pitanje o Mountain Health CO-OP, imate pravo da besplatno dobijete pomoć i informacije na Vašem jeziku. Da biste razgovarali sa prevodiocem, nazovite 855-447-2900.
- 만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Mountain Health CO-OP, 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 855-447-2900로 전화하십시오.
- Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Mountain Health CO-OP, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 855-447-2900.
- لديك الحق في الحصول على المساعدة والمعلومات في لغتك دون أي تكلفة. للتحدث مع مترجم، والدعوة، Mountain Health CO-OP، إذا كنت أنت أو شخص ما تحاول مساعدة، لديه تساؤلات حول 855-447-2900.
- Falls Sie oder jemand, dem Sie helfen, Fragen zum Mountain Health CO-OP, haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 855-447-2900 an.
- Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Mountain Health CO-OP, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 855-447-2900.
- Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Mountain Health CO-OP, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 855-447-2900.
- Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Mountain Health CO-OP, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 855-447-2900.
- ご本人様、またはお客様の身の回りの方でも、Mountain Health CO-OP, についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、855-447-2900までお電話ください。
- Dacă dumneavoastră sau persoana pe care o asistați aveți întrebări privind Mountain Health CO-OP, aveți dreptul de a obține gratuit ajutor și informații în limba dumneavoastră. Pentru a vorbi cu un interpret, sunați la 855-447-2990.

- To aan, malla goddo mo mballata, e yama dow Mountain Health CO-OP, a woodi baawde hebuki habaru malla wallireeki wolde maada naa maa a yobii. Mbolda e pirtoowo, nodda 855-447-2900.
- شما حق دریافت کمک و اطلاعات به زبان خود را بدون هیچ هزینه داشته باشد. برای صحبت با Mountain Health CO-OP، اگر شما یا کسی که شما در حال تلاش برای کمک به، سوالات در مورد یک مترجم، 2900-447-855 پاسخ.
- Якщо у Вас чи у когось, хто отримує Вашу допомогу, виникають питання про Mountain Health CO-OP, у Вас є право отримати безкоштовну допомогу та інформацію на Вашій рідній мові. Щоб зв'язатись з перекладачем, задзвоніть на 855-447-2900.

—————*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](#) \$7,900
- [Specialist \[cost sharing\]](#) 0% AD
- [Hospital \(facility\) \[cost sharing\]](#) 0% AD
- [Other \[cost sharing\]](#) 0% AD

#### 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*)

<b>Total Example Cost</b>	<b>\$12,731</b>
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#### In this example, Peg would pay:

Cost Sharing	
Deductibles	\$7900
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$7,960</b>

### Managing Joe's type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$7,900
- [Specialist \[cost sharing\]](#) 0% AD
- [Hospital \(facility\) \[cost sharing\]](#) 0% AD
- [Other \[cost sharing\]](#) 0% AD

#### 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*)

<b>Total Example Cost</b>	<b>\$7,389</b>
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#### In this example, Joe would pay:

Cost Sharing	
Deductibles	\$7184
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$55
<b>The total Joe would pay is</b>	<b>\$7239</b>

### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$7,900
- [Specialist \[cost sharing\]](#) 0% AD
- [Hospital \(facility\) \[cost sharing\]](#) 0% AD
- [Other \[cost sharing\]](#) 0% AD

#### This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$1,925</b>
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#### In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1925
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,925</b>