



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](http://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](http://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 <a href="#">deductible</a> ?                                | For <a href="#">network providers</a> : <b>\$2,000</b> individual <b>\$4,000</b> family;<br>For <a href="#">out-of-network providers</a> : <b>\$4,000</b> individual <b>\$8,000</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> 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>\$4,000</b> individual <b>\$8,000</b> family;<br>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.mountainhealth.coop/find-a-doctor">www.mountainhealth.coop/find-a-doctor</a> or call <b>1-855 447-2900</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> .  |

 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<br>(You will pay the least)                                       | Out-of-Network Provider<br>(You will pay the most)                                  |  |
| <b>If you visit a health care provider's office or clinic</b>  | Primary care visit to treat an injury or illness       | \$25 <a href="#">copay</a> / visit, <a href="#">deductible</a> does not apply      | 40% <a href="#">coinsurance</a>   | None   |
|  | <a href="#">Specialist</a> visit                       | \$50 <a href="#">copay</a> / visit, <a href="#">deductible</a> does not apply      | 40% <a href="#">coinsurance</a>   | None   |
|  | <a href="#">Preventive care/screening/immunization</a> | No Charge  | 40% <a href="#">coinsurance</a>   | 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.                                 |
| <b>If you have a test</b>  | <a href="#">Diagnostic test</a> (x-ray, blood work)    | 20% <a href="#">coinsurance</a>  | 40% <a href="#">coinsurance</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)                           | 20% <a href="#">coinsurance</a>  | 40% <a href="#">coinsurance</a>   | None   |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <a href="#">prescription drug coverage</a> is available at <a href="https://www.mountainhealth.coop/pharmacy">https://www.mountainhealth.coop/pharmacy</a> | Generic drugs  | \$10 <a href="#">copay</a> / medication, <a href="#">deductible</a> does not apply | \$20 <a href="#">copay</a> / medication, <a href="#">deductible</a> does not apply  | 30-day supply retail 90-day supply mail-order.   |
|  | Preferred brand drugs                                  | \$20 <a href="#">copay</a> / medication, <a href="#">deductible</a> does not apply | \$40 <a href="#">copay</a> / medication, <a href="#">deductible</a> does not apply  | 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                              | \$70 <a href="#">copay</a> / medication, <a href="#">deductible</a> does not apply | \$140 <a href="#">copay</a> / medication, <a href="#">deductible</a> does not apply | 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. |

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

| Common Medical Event  | Services You May Need                            | What You Will Pay   |  | Limitations, Exceptions, & Other Important Information                                    |
|---|--|---|--|---|
|   |  | Network Provider<br>(You will pay the least)  | Out-of-Network Provider<br>(You will pay the most)                                     |   |
|   | <a href="#">Specialty drugs</a>                  | \$120 <a href="#">copay</a> / medication, <a href="#">deductible</a> does not apply   | N/A  | 31-day supply Mail order not available. In-Network coverage limited to select pharmacies. |
| If you have outpatient surgery  | Facility fee (e.g., ambulatory surgery center)   | 20% <a href="#">coinsurance</a>   | 40% <a href="#">coinsurance</a>  | None  |
|   | Physician/surgeon fees                           | 20% <a href="#">coinsurance</a>   | 40% <a href="#">coinsurance</a>  | None  |
| If you need immediate medical attention                                   | <a href="#">Emergency room care</a>              | Office: \$250 <a href="#">copay</a> / visit, <a href="#">deductible</a> does not apply  | Office: \$250 <a href="#">copay</a> / visit, <a href="#">deductible</a> does not apply | None  |
|   | <a href="#">Emergency medical transportation</a> | 20% <a href="#">coinsurance</a>   | 20% <a href="#">coinsurance</a>  | None  |
|   | <a href="#">Urgent care</a>                      | Office: \$25 <a href="#">copay</a> / visit, <a href="#">deductible</a> does not apply   | 40% <a href="#">coinsurance</a>  | None  |
| If you have a hospital stay   | Facility fee (e.g., hospital room)               | 20% <a href="#">coinsurance</a>   | 40% <a href="#">coinsurance</a>  | None  |
|   | Physician/surgeon fees                           | 20% <a href="#">coinsurance</a>   | 40% <a href="#">coinsurance</a>  | None  |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                              | Office: \$0 <a href="#">copay</a> / visit, <a href="#">deductible</a> does not apply<br>Other: 20.00% <a href="#">coinsurance</a> | 40% <a href="#">coinsurance</a>  | None  |
|   | Inpatient services                               | 20% <a href="#">coinsurance</a>   | 40% <a href="#">coinsurance</a>  | None  |
| If you are pregnant   | Office visits                                    | Included in delivery  | Included in delivery   | None  |
|   | Childbirth/delivery professional services        | 20% <a href="#">coinsurance</a>   | 40% <a href="#">coinsurance</a>  | None  |
|   | Childbirth/delivery facility services            | 20% <a href="#">coinsurance</a>   | 40% <a href="#">coinsurance</a>  | None  |
| If you need help recovering or have other special health needs            | <a href="#">Home health care</a>                 | 20% <a href="#">coinsurance</a>   | 40% <a href="#">coinsurance</a>  | 180 visit / year  |
|   | <a href="#">Rehabilitation services</a>          | 20% <a href="#">coinsurance</a>   | 40% <a href="#">coinsurance</a>  | 20 visit / year each for physical, occupational, and speech therapy.                      |
|   | <a href="#">Habilitation services</a>            | 20% <a href="#">coinsurance</a>   | 40% <a href="#">coinsurance</a>  | 20 visit / year each for physical,  |

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| Common Medical Event   | Services You May Need                     | What You Will Pay                            |  | Limitations, Exceptions, & Other Important Information   |
|--|---|--|--|--|
|  |   | Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |  |
|  |   |  |  | occupational, and speech therapy.  |
|  | <a href="#">Skilled nursing care</a>      | 20% <a href="#">coinsurance</a>              | 40% <a href="#">coinsurance</a>                    | 60 days / year   |
|  | <a href="#">Durable medical equipment</a> | 20% <a href="#">coinsurance</a>              | 40% <a href="#">coinsurance</a>                    | See policy documents.  |
|  | <a href="#">Hospice services</a>          | 20% <a href="#">coinsurance</a>              | 40% <a href="#">coinsurance</a>                    | None   |
| <b>If your child needs hearing aids, dental care or eye care</b> | Children's eye exam                       | No Charge                                    | 25% <a href="#">coinsurance</a>                    | Coverage is limited to one Vision Examination per Covered Dependent Child under age 19, per Calendar Year. |
|  | Children's glasses                        | No Charge                                    | 25% <a href="#">coinsurance</a>                    | 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 <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> 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>Bariatric Surgery</li> <li>Dental Care</li> <li>Hearing Aids</li> <li>Infertility Treatment</li> <li></li> </ul> | <ul style="list-style-type: none"> <li>Long Term Care</li> <li>Non-emergency care when traveling outside the United States.</li> <li>Private-duty nursing unless the hospital does not have an urgent care or acute care unit.</li> <li>Religious counseling</li> <li>Reversal of an elective sterilization</li> </ul> | <ul style="list-style-type: none"> <li>Self-help programs</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>Acupuncture (Up to 12 visits/year)</li> <li>Chiropractic care (Up to 20 visits/year)</li> <li>Cosmetic surgery (Only if medically necessary or for certain reconstructive surgeries)</li> </ul> | <ul style="list-style-type: none"> <li>Dental Care up to \$100 limit, paid through reimbursement</li> <li>Routine eye care (adult) up to \$60 limit, paid through reimbursement</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> <li>Routine foot care provided to a member with Diabetes</li> </ul> |

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

**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](http://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 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](http://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 <a href="#">plan's</a> overall <a href="#">deductible</a> | \$4,400 |
| ■ <a href="#">Specialist cost sharing</a>                       | 0%      |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 0%      |
| ■ Other <a href="#">coinsurance</a>                             | 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*)

|                                   |                 |
|-----------------------------------|-----------------|
| <b>Total Example Cost</b>         | <b>\$12,700</b> |
| In this example, Peg would pay:   |                 |
| <i>Cost Sharing</i>               |                 |
| <a href="#">Deductibles</a>       | \$4,400         |
| <a href="#">Copayments</a>        | \$0             |
| <a href="#">Coinsurance</a>       | \$0             |
| <i>What isn't covered</i>         |                 |
| Limits or exclusions              | \$60            |
| <b>The total Peg would pay is</b> | <b>\$4,460</b>  |

### Managing Joe's Type 2 Diabetes

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

|   |         |
|---|---------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$4,400 |
| ■ <a href="#">Specialist cost sharing</a>                       | 0%      |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 0%      |
| ■ Other <a href="#">coinsurance</a>                             | 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*)

|                                   |                |
|-----------------------------------|----------------|
| <b>Total Example Cost</b>         | <b>\$5,600</b> |
| In this example, Joe would pay:   |                |
| <i>Cost Sharing</i>               |                |
| <a href="#">Deductibles</a>       | \$4,400        |
| <a href="#">Copayments</a>        | \$0            |
| <a href="#">Coinsurance</a>       | \$0            |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$20           |
| <b>The total Joe would pay is</b> | <b>\$4,420</b> |

### Mia's Simple Fracture

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

|   |         |
|---|---------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$4,400 |
| ■ <a href="#">Specialist cost sharing</a>                       | 0%      |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 0%      |
| ■ Other <a href="#">coinsurance</a>                             | 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*)

|                                   |                |
|-----------------------------------|----------------|
| <b>Total Example Cost</b>         | <b>\$2,800</b> |
| In this example, Mia would pay:   |                |
| <i>Cost Sharing</i>               |                |
| <a href="#">Deductibles</a>       | \$2,800        |
| <a href="#">Copayments</a>        | \$0            |
| <a href="#">Coinsurance</a>       | \$0            |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$2,800</b> |

