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.moutainhealth.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.gove/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: **$4,000** individual **$8,000** family; For out-of-network providers: **$9,000** individual **$18,000** 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: **$8,550** individual **$17,100** family; For out-of-network providers: **$24,450** individual **$48,900** 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.moutainhealth.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	$35 copay / visit, deductible does not apply	60% coinsurance	None
	Specialist visit	$75 copay / visit, deductible does not apply	60% coinsurance	None
	Preventive care/screening/ immunization	No Charge	60% 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)	50% coinsurance	60% 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)	50% coinsurance	60% 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	$10 copay / medication, deductible does not apply	60% coinsurance	30-day supply retail 90-day supply mail-order.
	Preferred brand drugs	$50 copay / medication, deductible does not apply	60% 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	$100 copay / medication, deductible does not apply	60% 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.

* 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 (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Specialty drugs	$150 copay / medication, deductible does not apply	60% coinsurance	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)	40% coinsurance	60% coinsurance	None
	Physician/surgeon fees	40% coinsurance	60% coinsurance	None
If you need immediate medical attention	Emergency room care	50% coinsurance	50% coinsurance	None
	Emergency medical transportation	50% coinsurance	50% coinsurance	None
	Urgent care	Office: $110 copay / visit, deductible does not apply	60% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	40% coinsurance	60% coinsurance	None
	Physician/surgeon fees	40% coinsurance	60% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: $0 first visit, then $35 copay / visit, deductible does not apply Other: 40% coinsurance	60% coinsurance	None
	Inpatient services	40% coinsurance	60% coinsurance	None
If you are pregnant	Office visits	Included in delivery	Included in delivery	None
	Childbirth/delivery professional services	40% coinsurance	60% coinsurance	None
	Childbirth/delivery facility services	40% coinsurance	60% coinsurance	None
If you need help recovering or have other special health needs	Home health care	40% coinsurance	60% coinsurance	180 visit / year
	Rehabilitation services	40% coinsurance	60% coinsurance	20 visit / year each for physical, occupational, and speech therapy.
	Habilitation services	40% coinsurance	60% coinsurance	20 visit / year each for physical,

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)	
				occupational, and speech therapy.
	Skilled nursing care	40% coinsurance	60% coinsurance	60 days / year
	Durable medical equipment	40% coinsurance	60% coinsurance	See policy documents.
	Hospice services	40% coinsurance	60% coinsurance	None
If your child needs hearing aids, dental care or eye care	Children's eye exam	No Charge	60% coinsurance	Coverage is limited to one Vision Examination per Covered Dependent Child under age 19, per Calendar Year.
	Children's glasses	No Charge	60% 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/cciio/Resources/Consumer-Assisatnace-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 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:	
Cost Sharing	
Deductibles	$4,400
Copayments	$0
Coinsurance	$0
What isn't covered	
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:	
Cost Sharing	
Deductibles	$4,400
Copayments	$0
Coinsurance	$0
What isn't covered	
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:	
Cost Sharing	
Deductibles	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**