



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 1-844-262-1560. 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 <https://www.healthcare.gov/sbc-glossary/> 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> : \$7,500 individual / \$15,000 family; for <a href="#">out-of-network providers</a> : \$15,000 individual / \$30,000 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> \$7,500 individual / \$15,000 family; for <a href="#">out-of-network providers</a> \$15,000 individual / \$30,000 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">www.mountainhealth.coop</a> or call 1-855 447-2900 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 visit to treat an injury or illness	0% after <a href="#">deductible</a>	0% after <a href="#">deductible</a>	None
	<a href="#">Specialist</a> visit	0% after <a href="#">deductible</a>	0% after <a href="#">deductible</a>	None
	<a href="#">Preventive care/screening/immunization</a>	No charge	0% after <a href="#">deductible</a>	(Out of network-Well Child Care visits covered at 100% before deductible; Mammograms covered at a minimum payment of \$70 before deductible)
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	0% after <a href="#">deductible</a>	0% 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)	0% after <a href="#">deductible</a>	0% 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/Montana/explore-plans/drug-list/">www.mhc.coop/Montana/explore-plans/drug-list/</a>	Preferred Generic Drugs (Tier 1)	0% after <a href="#">deductible</a> per drug /script for 31-day retail order or 90-day mail order	0% after <a href="#">deductible</a>	None
	Non-Preferred Generic & Preferred Brand Drugs (Tier 2)	0% after <a href="#">deductible</a> per drug /script for 31-day retail order or 90-day mail order	0% after <a href="#">deductible</a>	If you choose a higher Tier drug when a lower Tier drug is available, you must pay an ancillary charge in addition to the <a href="#">deductible</a> and/or <a href="#">coinsurance</a> , as applicable.
	Non-Preferred Brand Drugs (Tier 3)	0% after <a href="#">deductible</a> per drug /script for 31-day retail order or 90-day mail order	0% after <a href="#">deductible</a>	
	<a href="#">Specialty drugs</a>	0% after <a href="#">deductible</a> per drug /script for 31-day retail order or 90-day mail order	N/A	In-Network coverage limited to CVS retail
<b>If you have outpatient surgery</b>	Specialty Drugs (Tier 4)	0% after <a href="#">deductible</a> per drug /script for 31-day retail order or 90-day mail order	N/A	
	Facility fee (e.g., ambulatory surgery center)	0% after <a href="#">deductible</a>	0% 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)	
	Physician/surgeon fees	0% after <a href="#">deductible</a>	0% after <a href="#">deductible</a>	None
If you need immediate medical attention	<a href="#">Emergency room care</a>	0% after <a href="#">deductible</a>	0% after <a href="#">deductible</a>	None
	<a href="#">Emergency medical transportation</a>	0% after <a href="#">deductible</a>	0% after <a href="#">deductible</a>	None
	<a href="#">Urgent care</a>	0% after <a href="#">deductible</a>	0% after <a href="#">deductible</a>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	0% after <a href="#">deductible</a>	0% after <a href="#">deductible</a>	None
	Physician/surgeon fees	0% after <a href="#">deductible</a>	0% after <a href="#">deductible</a>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient Services Mental/Behavioral health Substance use disorder	0% after <a href="#">deductible</a>	0% after <a href="#">deductible</a>	None
	Inpatient services Mental/Behavioral health Substance use disorder	0% after <a href="#">deductible</a>	0% after <a href="#">deductible</a>	None
If you are pregnant	Office visits - Prenatal and postnatal care	0% after <a href="#">deductible</a>	0% after <a href="#">deductible</a>	None
	Childbirth/delivery professional services	0% after <a href="#">deductible</a>	0% after <a href="#">deductible</a>	None
	Childbirth/delivery facility services	0% after <a href="#">deductible</a>	0% after <a href="#">deductible</a>	None
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	0% after <a href="#">deductible</a>	0% after <a href="#">deductible</a>	180 visit limit/year
	<a href="#">Rehabilitation services</a>	0% after <a href="#">deductible</a>	0% after <a href="#">deductible</a>	None
	<a href="#">Habilitation services</a>	0% after <a href="#">deductible</a>	0% after <a href="#">deductible</a>	None
	<a href="#">Skilled nursing care</a>	0% after <a href="#">deductible</a>	0% after <a href="#">deductible</a>	60 day limit/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)	
	<a href="#">Durable medical equipment</a>	0% after <a href="#">deductible</a>	0% after <a href="#">deductible</a>	Preauthorization is required for original purchase or replacement of Durable Medical Equipment over \$500
	<a href="#">Hospice services</a>	0% after <a href="#">deductible</a>	0% after <a href="#">deductible</a>	None
If your child needs dental or eye care	Children’s eye exam	No charge	0% after <a href="#">deductible</a>	Coverage is limited to one Vision Examination per Covered Dependent Child per Calendar Year.
	Children’s glasses	No charge	0% after <a href="#">deductible</a>	Coverage is limited to one frame per Covered Dependent Child 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](#).)**

- |  |  |  |
|--|--|--|
| <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>• Hearing Aids</li> </ul> | <ul style="list-style-type: none"> <li>• Long-term care</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>• 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 [plan](#) document.)**

- |  |  |   |
|--|--|---|
| <ul style="list-style-type: none"> <li>• Chiropractic care (Up to 20 visits/year)</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.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596. 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 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: Montana Commissioner of Securities and Insurance, (406) 444-2040.

**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](#).

**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.
- 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.
- 如果你，或你正在帮助，拥有约蒙大拿州卫生CO-OP的问题，你有没有成本，以获取帮助和信息在你的语言的权利。交谈口译员，请致电 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。
- 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.
- 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.
- 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.
- 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 855-447-2900 로 전화하십시오.

- فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة، Mountain Health CO-OP، إن كان لديك أو لدى شخص تساعدك أسئلة بخصوص للتحدث مع مترجم اتصل بـ 855-447-2900.
- หากคุณ หรือคนที่ถูกก ำลังช่วยเหลือมีค าจามเกี่ยวกับ Mountain Health CO-OP คุณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย พูดคุยกับล่าม โทร 855-447-2900.
- Hvis du, eller noen du hjelper, har spørsmål om Mountain Health CO-OP, har du rett til å få hjelp og informasjon på ditt språk uten kostnad. For å snakke med en tolk, ring 855-447-2900.
- Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Mountian 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.
- 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.
- “Wann du hoscht en Froog, odder ebber, wu du helpscht, hot en Froog baut Mountain Health CO-OP, hoscht du es Recht fer Hilf un Information in deinre eegne Schprooch griege, un die Hilf koschtet nix. Wann du mit me Interpreter schwetze witt, kannscht du 855-447-2900 uffrufe.
- Se tu o qualcuno che stai aiutando avete domande su Mountain Health CO-OP, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 855-447-2900

*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*

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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](#) \$6,650
- [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>\$12,700</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
Deductibles	\$6650
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$6710</b>

**Managing Joe's type 2 Diabetes**  
(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$6,650
- [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>\$5,600</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
Deductibles	\$5,545
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$55
<b>The total Joe would pay is</b>	<b>\$5600</b>

**Mia's Simple Fracture**  
(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$6,650
- [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>\$2,800</b>
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**In this example, Mia would pay:**

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