




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 1-855-447-2900. 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/](http://www.healthcare.gov/sbc-glossary/) or call 1-800-318-2596 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	For <a href="#">network providers</a> : <b>\$6,500</b> individual <b>\$13,000</b> family; for <a href="#">out-of-network providers</a> : <b>\$13,500</b> individual <b>\$27,000</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> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	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> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	<b>No</b>	You don't have to meet deductibles for specific services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	For <a href="#">network providers</a> : <b>\$8,550</b> individual <b>\$17,100</b> family; for <a href="#">out-of-network providers</a> : <b>\$24,450</b> individual <b>\$48,900</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.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	<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> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	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.
<b>Do you need a <a href="#">referral</a> to</b>	<b>No</b>	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

Important Questions	Answers	Why This Matters:
see a <a href="#">specialist</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 (You will pay the least)	Out-of-Network Provider (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	\$60.00 <a href="#">copayment</a>	70% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None
	<a href="#">Specialist</a> visit	\$75.00 <a href="#">copayment</a> after <a href="#">deductible</a>	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>	None
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	60% <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)	60% <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="https://www.mountainhealth.coop/pharmacy">https://www.mountainhealth.coop/pharmacy</a>	Generic drugs	\$15.00 <a href="#">copayment</a> after <a href="#">deductible</a>	70% <a href="#">coinsurance</a> after <a href="#">deductible</a>	30-day supply retail; 90-day supply mail-order for 2x copay.
	Preferred brand drugs	\$75.00 <a href="#">copayment</a> after <a href="#">deductible</a>	70% <a href="#">coinsurance</a> after <a href="#">deductible</a>	30-day supply retail; 90-day supply mail-order for 2x copay. 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	\$125.00 <a href="#">copayment</a> after <a href="#">deductible</a>	70% <a href="#">coinsurance</a> after <a href="#">deductible</a>	30-day supply retail; 90-day supply mail-order for 2x copay. 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.
	<a href="#">Specialty drugs</a>	\$175.00 <a href="#">copayment</a>	70% <a href="#">coinsurance</a> after	30-day supply; Mail order not available. In-

[\* 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) after <a href="#">deductible</a>	Out-of-Network Provider (You will pay the most) <a href="#">deductible</a>	
				Network coverage limited to select pharmacies.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	70% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None
	Physician/surgeon fees	50% <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>	60% <a href="#">coinsurance</a> after <a href="#">deductible</a>	60% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None
	<a href="#">Emergency medical transportation</a>	60% <a href="#">coinsurance</a> after <a href="#">deductible</a>	60% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None
	<a href="#">Urgent care</a>	\$110.00 <a href="#">copayment</a>	70% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	70% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None
	Physician/surgeon fees	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	70% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$60.00 <a href="#">copayment</a>	70% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None
	Inpatient services	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	70% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None
If you are pregnant	Office visits	Included in delivery	Included in delivery	None
	Childbirth/delivery professional services	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	70% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None
	Childbirth/delivery facility services	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	70% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	70% <a href="#">coinsurance</a> after <a href="#">deductible</a>	180 visit limit/year
	<a href="#">Rehabilitation services</a>	\$75.00 <a href="#">copayment</a> after <a href="#">deductible</a>	70% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None
	<a href="#">Habilitation services</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	70% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None
	<a href="#">Skilled nursing care</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	70% <a href="#">coinsurance</a> 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>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	70% <a href="#">coinsurance</a> after <a href="#">deductible</a>	See policy documents.
	<a href="#">Hospice services</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	70% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None
<b>If your child needs hearing aids, dental care or eye care</b>	Children's eye exam	\$0.00	25% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Coverage is limited to one Vision Examination per Covered Dependent Child under age 19, per Calendar Year.
	Children's glasses	\$0.00	25% <a href="#">coinsurance</a> after <a href="#">deductible</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 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>• 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>• Chiropractic care (Up to 20 visits/year)</li> <li>• Acupuncture (Up to 12 visits/year)</li> </ul>	<ul style="list-style-type: none"> <li>• Cosmetic surgery (Only if medically necessary or for certain reconstructive surgeries)</li> <li>• Routine foot care provided to a member with Diabetes</li> </ul>	<ul style="list-style-type: none"> <li>• Non-emergency care when traveling outside the United States. See <a href="http://www.mountainhealth.coop">www.mountainhealth.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), HHS, DOL, and/or other applicable agency contact information]. 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

[\* 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.mountainhealth.coop](http://www.mountainhealth.coop) or call 1-855-447-2900.

#### **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:**

SPANISH: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-447-2900.

CHINESE: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-447-2900。

SERBO-CROATION: U ovom obavještenju su sadržane važne informacije. U ovom obavještenju su sadržane važne informacije o Vašoj prijavi ili osiguranju preko MHC. Pogledajte

nalaze li se u ovom obavještenju nekih ključni datumi. Možda ćete morati poduzeti određene radnje u datom roku kako biste i dalje zadržali svoje osiguranje ili pomoć pri plaćanju. Imate pravo da ove informacije, kao i pomoć, dobijete besplatno na svom jeziku. Nazovite 1-855-447-2900.

KOREAN: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-xxx-xxx-xxxx (TTY: 1-xxx-xxx-xxxx) 번으로 전화해 주십시오. 1-855-447-2900

VIETNAMESE: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-447-2900.

ARABIC: يحوي هذا إشعار معلومات هامة. يحوي هذا شعار معلومات مهمة بخصوص طلبك للحصول على التغطية من قبل ابحت عن التواريخ ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة

(. اللغوية تتوافر لك بالمجان. اتصل برقم 1 - 855-447-2900 (رقم هاتف الصم والبكم: 1 - 855-447-2900)

GERMAN: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-447-2900.

TAGALOG: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-447-2900.

RUSSIAN: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-447-2900.

FRENCH: ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-447-2900.

ITALIAN: ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-447-2900.

JAPANESE: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-855-447-2900（TTY:1-855-447-2900）まで、お電話にてご連絡ください。

THAI: เรียน: หากคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-855-447-2900 (TTY: 1-855-447-2900).

ROMANIAN: ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-855-447-2900.

SUDANIC-FULFULDE: Anndinoore nde'e e woodi habaru kimminiidum. TAnndinoore nde'e e woodi habaru kimminiidum dow dereewol tefal maadamaada malla ko yaali dow laawol MHC. Maanda nyalaade lewru nder anndinoorende'e. Teema a gideteedo ngaada goddum bako godde nyalaade ngam ko yaali njamu maada malla walla dow njobdi. Hakke maada annda habaru ngu'u ewalliinde nder wolde maada naa maa a yobii. Noddu 1-855-447-2900.



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**BANTU: ICITONDERWA:** Nimba uvugako Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona 1-855-447-2900 (TTY: 1-855-447-2900).

**NORWEGIAN: MERK:** Hvis du snakker norsk, er gratis språkassistanstjenester tilgjengelige for deg. Ring 1-855-447-2900.

**PENNSYLVANIA DUTCH:** Wann du Deitsch (Pennsylvania German / Dutch) schwetzsch, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-855-447-2900.

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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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$6,500
■ <a href="#">Specialist</a> [ <a href="#">cost sharing</a> ]	\$75
■ Hospital (facility) [ <a href="#">cost sharing</a> ]	50%
■ Other [ <a href="#">cost sharing</a> ]	50%

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>	
<a href="#">Deductibles</a>	\$6,500
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$1,700
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$8,270</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>	\$6,500
■ <a href="#">Specialist</a> [ <a href="#">cost sharing</a> ]	\$75
■ Hospital (facility) [ <a href="#">cost sharing</a> ]	50%
■ Other [ <a href="#">cost sharing</a> ]	50%

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>	
<a href="#">Deductibles</a>	\$4,700
<a href="#">Copayments</a>	\$400
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$5,120</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>	\$6,500
■ <a href="#">Specialist</a> [ <a href="#">cost sharing</a> ]	\$75
■ Hospital (facility) [ <a href="#">cost sharing</a> ]	50%
■ Other [ <a href="#">cost sharing</a> ]	50%

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>	
<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>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.