




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 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/glossary](http://www.healthcare.gov/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>	<a href="#">Network provider</a> : \$1,000/ individual or \$2,000/ family <a href="#">Out-of-network provider</a> : \$3,000/ individual or \$6,000/ 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> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	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> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	No	You don't have to meet <a href="#">deductibles</a> for specific services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	<a href="#">Network provider</a> : \$6,000/ individual or \$12,000/ family <a href="#">Out-of-network provider</a> : \$17,250/ individual or \$34,500/ 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> for 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/find-a-doctor">www.mountainhealth.coop/find-a-doctor</a> or call 1-855-447-2900 for a list of <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 <a href="#">plan's 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 <a href="#">provider's</a> 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 see a <a href="#">specialist</a>?</b>	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 (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <a href="#">provider's office</a> or <a href="#">clinic</a>	Primary care visit to treat an injury or illness	\$35 <a href="#">copayment</a> /visit, <a href="#">deductible</a> does not apply	50% <a href="#">coinsurance</a>	None
	<a href="#">Specialist</a> visit	\$50 <a href="#">copayment</a> /visit, <a href="#">deductible</a> does not apply	50% <a href="#">coinsurance</a>	None
	<a href="#">Preventive care/screening/immunization</a>	No charge	50% <a href="#">coinsurance</a>	Frequency limitations apply. You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	40% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> may be required. See Section 6 of policy document for more information.
	Imaging (CT/PET scans, MRIs)	40% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.mountainhealth.coop/pharmacy">www.mountainhealth.coop/pharmacy</a> .	Generic drugs	Retail: 10% <a href="#">coinsurance</a> , <a href="#">deductible</a> does not apply Mail Order: 10% <a href="#">coinsurance</a> , <a href="#">deductible</a> does not apply	50% <a href="#">coinsurance</a>	Covers up to a 30-day supply (retail subscription); 30-90 day supply (mail order prescription).
	Preferred brand drugs	Retail: 25% <a href="#">coinsurance</a> , <a href="#">deductible</a> does not apply Mail Order 25% <a href="#">coinsurance</a> , <a href="#">deductible</a> does not apply	50% <a href="#">coinsurance</a>	Covers up to a 30-day supply (retail subscription); 30-90-day supply (mail order prescription). If you choose a higher Tier drug when a lower Tier drug is available, you may be subject to additional member responsibility.
	Non-preferred brand drugs	Retail: 35% <a href="#">coinsurance</a> , <a href="#">deductible</a> does not apply Mail Order 35% <a href="#">coinsurance</a> , <a href="#">deductible</a> does not apply	50% <a href="#">coinsurance</a>	

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

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="#">Specialty drugs</a>	45% <a href="#">coinsurance</a> , <a href="#">deductible</a> does not apply	50% <a href="#">coinsurance</a>	Covers up to a 30-day supply (retail subscription); mail order not available. <a href="#">Provider network</a> limited to select pharmacies.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> may be required. See Section 6 of policy document for more information.
	Physician/surgeon fees	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
If you need immediate medical attention	<a href="#">Emergency room care</a>	40% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
	<a href="#">Emergency medical transportation</a>	40% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
	<a href="#">Urgent care</a>	\$75 <a href="#">copayment</a> /visit, <a href="#">deductible</a> does not apply	50% <a href="#">coinsurance</a>	
If you have a hospital stay	Facility fee (e.g., hospital room)	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> may be required. See Section 6 of policy document for more information.
	Physician/surgeon fees	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: \$35 <a href="#">copayment</a> /visit, <a href="#">deductible</a> does not apply Other: 30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> may be required. See Section 6 of policy document for more information.
	Inpatient services	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
If you are pregnant	Office visits	\$35 <a href="#">copayment</a> /visit, <a href="#">deductible</a> does not apply	50% <a href="#">coinsurance</a>	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of services, a <a href="#">coinsurance</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). <a href="#">Preauthorization</a> may be required. See Section 6 of policy document for more information.
	Childbirth/delivery professional services	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	180 visits/year. <a href="#">Preauthorization</a> may be required. See Section 6 of policy document for more information.
	<a href="#">Rehabilitation services</a>	Office: \$50 <a href="#">copayment</a> /visit,	50% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> may be required. See Section 6 of

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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="#">deductible</a> does not apply Other: 30% <a href="#">coinsurance</a>		policy document for more information.
	<a href="#">Habilitation services</a>	Office: \$50 <a href="#">copayment</a> /visit, <a href="#">deductible</a> does not apply Other: 30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> may be required. See Section 6 of policy document for more information.
	<a href="#">Skilled nursing care</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	60 days/year. <a href="#">Preauthorization</a> may be required. See Section 6 of policy document for more information.
	<a href="#">Durable medical equipment</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> may be required. See Section 6 of policy document for more information.
	<a href="#">Hospice services</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> may be required. See Section 6 of policy document for more information.
<b>If your child needs dental or eye care</b>	Children's eye exam	No Charge	25% <a href="#">coinsurance</a>	Coverage is limited to one exam/year for those under age 19.
	Children's glasses	No Charge	25% <a href="#">coinsurance</a>	Coverage is limited to one pair of eyeglasses/year for those under age 19.
	Children's dental check-up	Not Covered	Not Covered	Not Covered

#### 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 in danger</li> <li>Bariatric Surgery</li> </ul>	<ul style="list-style-type: none"> <li>Dental Care (Child)</li> <li>Hearing Aids (Adult)</li> </ul>	<ul style="list-style-type: none"> <li>Long Term Care</li> <li>Private-duty nursing</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 for certain reconstructive surgeries</li> <li>Dental Care (Adult) - up to \$100 limit</li> </ul>	<ul style="list-style-type: none"> <li>Hearing Aids (Child) - - <a href="#">Preauthorization</a> required</li> <li>Infertility treatment, except invitro fertilization</li> <li>Non-emergency care when traveling outside the United States. See <a href="http://www.mountainhealth.coop/plan-listing">www.mountainhealth.coop/plan-listing</a> for more</li> </ul>	<ul style="list-style-type: none"> <li>Routine eye care (Adult) - up to \$60 limit</li> <li>Routine foot care provided to a member with Diabetes</li> <li>Weight loss programs - <a href="#">Preauthorization</a> required</li> </ul>

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

**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)**

information.

**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 1-855-447-2900. State insurance department at 1-866-444-3272 or <https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa>. State consumer assistance program at <https://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants>. 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.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](#).

*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](#) \$1,000
- [Specialist copayment](#) \$50
- Hospital (facility) [coinsurance](#) 30%
- Other [coinsurance](#) 30%

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>	\$1,000
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$3,500
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$4,560</b>

### Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$1,000
- [Specialist copayment](#) \$50
- Hospital (facility) [coinsurance](#) 30%
- Other [coinsurance](#) 30%

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>	\$900
<a href="#">Copayments</a>	\$400
<a href="#">Coinsurance</a>	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,620</b>

### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$1,000
- [Specialist copayment](#) \$50
- Hospital (facility) [coinsurance](#) 30%
- Other [coinsurance](#) 30%

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>	\$1,000
<a href="#">Copayments</a>	\$400
<a href="#">Coinsurance</a>	\$400
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,800</b>

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