




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> : \$6,400/ individual or \$12,800/ family<br><a href="#">Out-of-network provider</a> : \$17,100 / individual or \$34,200 / 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> \$8,150 / individual or \$16,300 / family<br><a href="#">Out-of-network provider</a> : \$24,450 / individual or \$48,900 / 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<br>(You will pay the least)   | Out-of-Network Provider<br>(You will pay the most) |  |
| If you visit a health care <a href="#">provider's office</a> or clinic   | Primary care visit to treat an injury or illness        | \$0 <a href="#">copayment</a> /visit<br><a href="#">deductible</a> does not apply  | 50% <a href="#">coinsurance</a>                    | None   |
|  | <a href="#">Specialist</a> visit                        | \$75 <a href="#">copayment</a> /visit  | 50% <a href="#">coinsurance</a>                    | None   |
|  | <a href="#">Preventive care/screening</a> /immunization | 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)     | 50% <a href="#">coinsurance</a>  | 50% <a href="#">coinsurance</a>                    | <a href="#">Preauthorization</a> may be required. See policy document for more information.  |
|  | Imaging (CT/PET scans, MRIs)                            | 50% <a href="#">coinsurance</a>  | 50% <a href="#">coinsurance</a>                    |  |
| If you need drugs to treat your illness or condition<br>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="#">copayment</a> /prescription, <a href="#">deductible</a> does not apply<br>Mail Order: \$20 <a href="#">copayment</a> /prescription, <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: \$60 <a href="#">copayment</a> /prescription, <a href="#">deductible</a> does not apply<br>Mail Order \$120 <a href="#">copayment</a> /prescription, <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, as applicable. |
|  | Non-preferred brand drugs                               | Retail: \$150 <a href="#">copayment</a> /prescription,   | 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<br>(You will pay the least)   | Out-of-Network Provider<br>(You will pay the most) |  |
|  |  | <a href="#">deductible</a> does not apply<br>Mail Order \$300<br><a href="#">copayment</a> /prescription,<br><a href="#">deductible</a> does not apply |  |  |
|  | <a href="#">Specialty drugs</a>                  | Retail: \$200<br><a href="#">copayment</a> /prescription,<br><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. |
| <b>If you have outpatient surgery</b>  | 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 policy document for more information.  |
|  | Physician/surgeon fees                           | 30% <a href="#">coinsurance</a>  | 50% <a href="#">coinsurance</a>                    |  |
| <b>If you need immediate medical attention</b>                                   | <a href="#">Emergency room care</a>              | 50% <a href="#">coinsurance</a>  | 50% <a href="#">coinsurance</a>                    | None   |
|  | <a href="#">Emergency medical transportation</a> | 50% <a href="#">coinsurance</a>  | 50% <a href="#">coinsurance</a>                    |  |
|  | <a href="#">Urgent care</a>                      | \$110 <a href="#">copayment</a> /visit<br><a href="#">deductible</a> does not apply  | 50% <a href="#">coinsurance</a>                    |  |
| <b>If you have a hospital stay</b>   | Facility fee (e.g., hospital room)               | 30% <a href="#">coinsurance</a>  | 50% <a href="#">coinsurance</a>                    | <a href="#">Preauthorization</a> may be required. See policy document for more information.  |
|  | Physician/surgeon fees                           | 30% <a href="#">coinsurance</a>  | 50% <a href="#">coinsurance</a>                    |  |
| <b>If you need mental health, behavioral health, or substance abuse services</b> | Outpatient services                              | Office: \$0<br><a href="#">copayment</a> /visit<br><a href="#">deductible</a> does not apply<br>Other: 30%<br><a href="#">coinsurance</a>              | 50% <a href="#">coinsurance</a>                    | <a href="#">Preauthorization</a> may be required. See policy document for more information.  |
|  | Inpatient services                               | 30% <a href="#">coinsurance</a>  | 50% <a href="#">coinsurance</a>                    |  |
| <b>If you are pregnant</b>   | Office visits                                    | \$0 <a href="#">copayment</a> /visit<br><a href="#">deductible</a> does not  | 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,                     |

\* 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<br>(You will pay the least)   | Out-of-Network Provider<br>(You will pay the most) |   |
|   |   | apply  |  | 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 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>                    |   |
| <b>If you need help recovering or have other special health needs</b> | <a href="#">Home health care</a>          | 30% <a href="#">coinsurance</a>  | 50% <a href="#">coinsurance</a>                    | <a href="#">Preauthorization</a> may be required. See policy document for more information.   |
|   | <a href="#">Rehabilitation services</a>   | Office: \$75 <a href="#">copayment</a> /visit,<br>Other: 30% <a href="#">coinsurance</a> | 50% <a href="#">coinsurance</a>                    | 20 visits/year. <a href="#">Preauthorization</a> may be required. See policy document for more information.   |
|   | <a href="#">Habilitation services</a>     | Office: \$75 <a href="#">copayment</a> /visit,<br>Other: 30% <a href="#">coinsurance</a> | 50% <a href="#">coinsurance</a>                    | 20 visits/year. <a href="#">Preauthorization</a> may be required. See policy document for more information.   |
|   | <a href="#">Skilled nursing care</a>      | 30% <a href="#">coinsurance</a>  | 50% <a href="#">coinsurance</a>                    | 30 days/year. <a href="#">Preauthorization</a> may be required. See 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 policy document for more information.   |
|   | <a href="#">Hospice services</a>          | 30% <a href="#">coinsurance</a>  | 50% <a href="#">coinsurance</a>                    | \$10,000/Lifetime Maximum. <a href="#">Preauthorization</a> may be required. See 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:**

|   |   |  |
|---|---|--|
| <b>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>.)</b> |   |  |
| <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> |

\* 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).

**Services Your [Plan](#) Generally Does NOT Cover (Check your policy or [plan](#) document for more information and a list of any other [excluded services](#).)**

- 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 maximum
- Cosmetic surgery - Only if medically necessary for certain reconstructive surgeries
- Dental Care (Adult) - up to \$100 limit
- Hearing Aids (Child) - [Preauthorization](#) required
- Non-emergency care when traveling outside the United States. See [www.mountainhealth.coop/plan-listing](http://www.mountainhealth.coop/plan-listing) for more information.
- Routine eye care (Adult) - up to \$60 limit
- 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 1-855-447-2900. State insurance department at 1-800-721-3272 or at [doi.idaho.gov](http://doi.idaho.gov). Other coverage options may be available to you, too, including buying individual insurance coverage through Your Health Idaho. For more information about Your Health Idaho, visit [www.yourhealthidaho.org](http://www.yourhealthidaho.org) or call 855-944-3246.

**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 or the Idaho Department of Insurance at 1-800-721-3272 or at [www.doi.idaho.gov](http://www.doi.idaho.gov).

**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](#) \$6,400
- [Specialist copayment](#) \$75
- 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> |
|---------------------------|-----------------|

In this example, Peg would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$6,400        |
| <a href="#">Copayments</a>        | \$10           |
| <a href="#">Coinsurance</a>       | \$1800         |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$8,070</b> |

### Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$6,400
- [Specialist copayment](#) \$75
- 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> |
|---------------------------|----------------|

In this example, Joe would pay:

| <i>Cost Sharing</i>               |               |
|-----------------------------------|---------------|
| <a href="#">Deductibles</a>       | \$900         |
| <a href="#">Copayments</a>        | \$2200        |
| <a href="#">Coinsurance</a>       | \$0           |
| <i>What isn't covered</i>         |               |
| Limits or exclusions              | \$20          |
| <b>The total Joe would pay is</b> | <b>\$3120</b> |

### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$6,400
- [Specialist copayment](#) \$75
- 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> |
|---------------------------|----------------|

In this example, Mia would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$2,500        |
| <a href="#">Copayments</a>        | \$200          |
| <a href="#">Coinsurance</a>       | \$0            |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$2,700</b> |

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