




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:
What is the overall <a href="#">deductible</a> ?	<a href="#">Network provider</a> : \$5,500/ individual or \$11,000/ family <a href="#">Out-of-network provider</a> : \$15,600 / individual or \$31,200 / 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> .
Are there services covered before you meet your <a href="#">deductible</a> ?	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> .
Are there other <a href="#">deductibles</a> for specific services?	No	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	<a href="#">Network provider</a> \$9,000 / individual or \$18,000/ family <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.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<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> .
Will you pay less if you use a <a href="#">network provider</a> ?	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.

Important Questions	Answers	Why This Matters:
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> .

 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 or clinic</a>	Primary care visit to treat an injury or illness	\$40 <a href="#">copayment</a> /visit, <a href="#">deductible</a> does not apply	60% <a href="#">coinsurance</a>	None
	<a href="#">Specialist</a> visit	\$75 <a href="#">copayment</a> /visit, <a href="#">deductible</a> does not apply	60% <a href="#">coinsurance</a>	None
	<a href="#">Preventive care/screening/immunization</a>	No charge	60% <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>	60% <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)	50% <a href="#">coinsurance</a>	60% <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="#">copayment</a> /prescription, <a href="#">deductible</a> does not apply Mail Order: \$20 <a href="#">copayment</a> /prescription, <a href="#">deductible</a> does not apply	60% <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 Mail Order: \$120 <a href="#">copayment</a> /prescription, <a href="#">deductible</a> does not apply	60% <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: \$150 <a href="#">copayment</a> /prescription,	60% <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="#">deductible</a> does not apply Mail Order: \$300 <a href="#">copayment</a> /prescription, <a href="#">deductible</a> does not apply		
	<a href="#">Specialty drugs</a>	\$200 <a href="#">copayment</a> /prescription, <a href="#">deductible</a> does not apply	60% <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)	40% <a href="#">coinsurance</a>	60% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> may be required. See Section 6 of policy document for more information.
	Physician/surgeon fees	40% <a href="#">coinsurance</a>	60% <a href="#">coinsurance</a>	
If you need immediate medical attention	<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, <a href="#">deductible</a> does not apply	60% <a href="#">coinsurance</a>	
If you have a hospital stay	Facility fee (e.g., hospital room)	40% <a href="#">coinsurance</a>	60% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> may be required. See Section 6 of policy document for more information.
	Physician/surgeon fees	40% <a href="#">coinsurance</a>	60% <a href="#">coinsurance</a>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: First visit \$0, then \$40 <a href="#">copayment</a> /visit, <a href="#">deductible</a> does not apply Other: 40% <a href="#">coinsurance</a>	60% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> may be required. See Section 6 of policy document for more information.
	Inpatient/Outpatient services	40% <a href="#">coinsurance</a>	60% <a href="#">coinsurance</a>	
If you are pregnant	Office visits	\$40 <a href="#">copayment</a> /visit, <a href="#">deductible</a> does not apply	60% <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	40% <a href="#">coinsurance</a>	60% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	40% <a href="#">coinsurance</a>	60% <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)	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	40% <a href="#">coinsurance</a>	60% <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: \$75 <a href="#">copayment</a> /visit, <a href="#">deductible</a> does not apply Other: 40% <a href="#">coinsurance</a>	60% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> may be required. See Section 6 of policy document for more information.
	<a href="#">Habilitation services</a>	Office: \$75 <a href="#">copayment</a> /visit, <a href="#">deductible</a> does not apply Other: 40% <a href="#">coinsurance</a>	60% <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>	40% <a href="#">coinsurance</a>	60% <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>	40% <a href="#">coinsurance</a>	60% <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>	40% <a href="#">coinsurance</a>	60% <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> </ul>	<ul style="list-style-type: none"> <li>Hearing Aids (Child) - <a href="#">Preauthorization</a> required</li> <li>Infertility treatment, except invitro fertilization</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</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.)**

- Cosmetic surgery - Only if medically necessary for certain reconstructive surgeries
- Dental Care (Adult) - up to \$100 limit
- Non-emergency care when traveling outside the United States. See [www.mountainhealth.coop/plan-listing](http://www.mountainhealth.coop/plan-listing) for more information.
- Diabetes
- Weight loss programs - [Preauthorization](#) required

**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: For group health coverage subject to ERISA contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa.healthreform](http://www.dol.gov/ebsa.healthreform). For non-federal governmental group health plans contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323 x 61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). Church plans are not covered by the Federal COBRA continuation rules. If the coverage is insurance individuals should contact their State Insurance Department regarding their possible rights to continue coverage. 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. You may also contact the Department of Labor's Employee Benefit Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).

**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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including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

## 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](#) \$5,500
- [Specialist copayment](#), \$75
- Hospital (facility) [coinsurance](#) 40%
- Other [coinsurance](#) 40%

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:

Cost Sharing	
<a href="#">Deductibles</a>	\$5,500
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$2,800
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$8,370</b>

### Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$5,500
- [Specialist copayment](#), \$75
- Hospital (facility) [coinsurance](#) 40%
- Other [coinsurance](#) 40%

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:

Cost Sharing	
<a href="#">Deductibles</a>	\$1,300
<a href="#">Copayments</a>	\$1,200
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$2,520</b>

### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$5,500
- [Specialist copayment](#), \$75
- Hospital (facility) [coinsurance](#) 40%
- Other [coinsurance](#) 40%

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:

Cost Sharing	
<a href="#">Deductibles</a>	\$2,500
<a href="#">Copayments</a>	\$200
<a href="#">Coinsurance</a>	\$0
What isn't covered	
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.