




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 or call 800-299-6080. 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 or call 1-800-318-2596 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network provider : \$10,600/ individual or \$21,200/ family. Out-of-network provider : \$21,000/ individual or \$42,000/ family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible .
Are there services covered before you meet your deductible?	Yes. Preventive care and primary care services are covered before you meet your deductible .	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Network provider : \$10,600/ individual or \$21,200/ family Out-of-network provider : \$36,800/ individual or \$73,600/ family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Copayments for certain services, premiums , balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Will you pay less if you use a network provider?	Yes. See www.mountainhealth.coop/find-a-doctor or call 1-800-299-6080 for a list of network providers .	This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to	No	You can see the specialist you choose without a referral .

Important Questions	Answers	Why This Matters:
see a specialist ?		

 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 provider's office or clinic	Primary care visit to treat an injury or illness	\$0 copayment deductible does not apply	20% coinsurance	None
	Specialist visit	\$120 deductible does not apply	20% coinsurance	None
	Preventive care/screening/immunization	No charge	20% coinsurance	Frequency limitations apply. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	\$0 coinsurance	20% coinsurance	* Preauthorization may be required. See policy document for more information.
	Imaging (CT/PET scans, MRIs)	0% coinsurance	20% coinsurance	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.mountainhealth.coop/pharmacy .	Generic drugs	Retail: \$20 copayment/prescription deductible does not apply Mail Order: \$40 copayment/prescription deductible does not apply	20% coinsurance	Covers up to a 30-day supply (retail subscription); 30-90 day supply (mail order prescription).
	Preferred brand drugs	0% coinsurance	20% coinsurance	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 must pay an ancillary charge in addition to the deductible , copayment or coinsurance as applicable.
	Non-preferred brand drugs	0% coinsurance	20% coinsurance	

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

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)	
	Specialty drugs	\$0 copayment	20% coinsurance	Covers up to a 30-day supply (retail subscription); mail order not available. Provider network limited to select pharmacies.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	20% coinsurance	* Preauthorization may be required. See policy document for more information.
	Physician/surgeon fees	0% coinsurance	20% coinsurance	
If you need immediate medical attention	Emergency room care	0% coinsurance	0% coinsurance	None
	Emergency medical transportation	0% coinsurance	0% coinsurance	
	Urgent care	\$110 copayment deductible does not apply	20% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	20% coinsurance	* Preauthorization may be required. See policy document for more information.
	Physician/surgeon fees	0% coinsurance	20% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$0 copayment deductible does not apply Other: 0% coinsurance	20% coinsurance	* Preauthorization may be required. See policy document for more information.
	Inpatient services	0% coinsurance	20% coinsurance	
If you are pregnant	Office visits	\$0 copayment deductible does not apply	20% coinsurance	* Cost sharing does not apply for preventive services . Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Preauthorization may be required. See policy document for more information.
	Childbirth/delivery professional services	0% coinsurance	20% coinsurance	
	Childbirth/delivery facility services	0% coinsurance	20% coinsurance	
If you need help recovering or have other special health needs	Home health care	0% coinsurance	20% coinsurance	* Preauthorization may be required. See policy document for more information.
	Rehabilitation services	Outpatient: \$120 copayment, deductible	20% coinsurance	* Preauthorization may be required. See policy document for more information.

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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)	
		does not apply 0% coinsurance		
	Habilitation services	Outpatient: \$120 copayment , deductible does not apply 0% coinsurance	20% coinsurance	* Preauthorization may be required. See policy document for more information.
	Skilled nursing care	Other: 0% coinsurance	20% coinsurance	* Preauthorization may be required. See policy document for more information.
	Durable medical equipment	0% coinsurance	20% coinsurance	
	Hospice services	0% coinsurance	20% coinsurance	
If your child needs dental or eye care	Children's eye exam	No Charge	25% coinsurance	Coverage is limited to one exam/year for those under age 19.
	Children's glasses	No Charge	25% coinsurance	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 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"> Abortion - except in the case of rape, incest, or when the life of the mother is in danger Bariatric surgery 	<ul style="list-style-type: none"> Dental care (Child) Hearing aids (Adult) Non-emergency care when traveling outside the United States. 	<ul style="list-style-type: none"> Long term care Private-duty nursing Weight Loss Programs

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"> 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 	<ul style="list-style-type: none"> Hearing Aids (Child) - Preauthorization required under age 19, one per ear every three years 	<ul style="list-style-type: none"> Routine eye care (Adult) - up to \$60 limit Routine foot care provided to a member with Diabetes

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

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 1-800-299-6080. State insurance department at 1-800-721-3272 or at 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 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 or call 1-800-299-6080 or the Idaho Department of Insurance at 1-800-721-3272 or at 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](#) \$9000
- [Specialist copayment](#) \$120
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 0%

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*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$9000
Copayments	\$0
Coinsurance	\$1500
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$10,560

Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$9000
- [Specialist copayment](#) \$120
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 0%

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*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$900
Copayments	\$700
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1620

Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$9000
- [Specialist copayment](#) \$120
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 0%

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)
[Diagnostic test](#) (*x-ray*)
[Durable medical equipment](#) (*crutches*)
[Rehabilitation services](#) (*physical therapy*)

Total Example Cost	\$2,800
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$2,100
Copayments	\$600
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$2700

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