**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.mhc.coop or call 1-844-262-1560. 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 https://www.healthcare.gov/sbc-glossary/ or call 1-800-318-2596 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | For network providers: **$1,000** individual / **$2,000** family; for out-of-network providers: **$2,000** individual / **$4,000** 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 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?** | For network providers **$4,500** individual / **$9,000** family; for out-of-network providers **$9,000** individual / **$18,000** 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 on 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.mhc.coop** or call **1-855 447-2900** for information regarding 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 see a specialist?** | No | You can see the specialist you choose without a referral. |


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Most 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 | $35 Copay | 50% After Deductible | None |
| | Specialist visit | $40 Copay | 50% After Deductible | None |
| | Preventive care/screening/ immunization | No Charge | 50% After Deductible | (Out of network-Well Child Care visits covered at 100% before deductible; Mammograms covered at a minimum payment of $70 before deductible) |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 30% After Deductible | 50% After Deductible | 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) | 30% After Deductible | 50% After Deductible | None |
| **If you need drugs to treat your illness or condition** More information about prescription drug coverage is available at www.mhc.coop/Montana/explore-plans/drug-list/ | Preferred Generic Drugs (Tier 1) | $10 Copay per drug/script for 31-day retail order or $20 Copay for 90-day mail order | 50% After Deductible | None |
| | Non-Preferred Generic & Preferred Brand Drugs (Tier 2) | $30 Copay per drug/script for 31-day retail order or $60 Copay for 90-day mail order | 50% After Deductible | 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. |
| | Non-Preferred Brand Drugs (Tier 3) | $150 Copay per drug/script for 31-day retail order after deductible or $300 Copay for 90-day mail order after deductible | 50% After Deductible | |
| | Specialty drugs Specialty Drugs (Tier 4) | 50% After Deductible | Not Available | In-Network coverage limited to CVS retail |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 30% After Deductible | 50% After Deductible | None |
| | Physician/surgeon fees | 30% After deductible | 50% After Deductible | None |

| 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 need immediate medical attention** | Emergency room care | $100 Copay per visit after deductible | $100 Copay per visit after deductible | None |
| | Emergency medical transportation | 30% After Deductible | 50% After deductible | None |
| | Urgent care | $100 Copay per visit after deductible | $100 Copay per visit after deductible | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 30% After Deductible | 50% After Deductible | None |
| | Physician/surgeon fees | 30% After Deductible | 50% After Deductible | None |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient Services<br>Mental/Behavioral health<br>Substance use disorder | $35 Copay | 50% After Deductible | None |
| | Inpatient services<br>Mental/Behavioral health<br>Substance use disorder | 30% After Deductible | 50% After Deductible | None |
| **If you are pregnant** | Office visits - Prenatal and postnatal care | $35 copay/office visit and 30% coinsurance for other outpatient services | 50% After Deductible | None |
| | Childbirth/delivery professional services | 30% After Deductible | 50% After Deductible | None |
| | Childbirth/delivery facility services | 30% After Deductible | 50% After Deductible | None |
| **If you need help recovering or have other special health needs** | Home health care | 30% After Deductible | 50% After Deductible | 180 visit limit/year |
| | Rehabilitation services | 30% After Deductible | 50% After Deductible | None |
| | Habilitation services | 30% After Deductible | 50% After Deductible | None |
| | Skilled nursing care | 30% After Deductible | 50% After Deductible | 60 day limit/year |
| | Durable medical equipment | 30% After Deductible | 50% After Deductible | Preauthorization is required for original purchase or replacement of Durable Medical Equipment over $500 |
| | Hospice services | 30% After Deductible | 50% After deductible | None |


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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) | |
| **If your child needs dental or eye care** | Children's eye exam | No charge | 25% After Deductible | Coverage is limited to one Vision Examination per Covered Dependent Child per Calendar Year. |
| | Children's glasses | No charge | 25% After Deductible | Coverage is limited to one frame per Covered Dependent Child per Calendar Year. |
| | Children's dental check-up | Not covered | Not covered | None |

## 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.)**

- Abortion (except in the case of rape, incest, or when the life of the mother is endangered)
- Acupuncture
- Bariatric surgery
- Dental care and treatment
- Hearing Aids
- Long-term care
- Private-duty nursing
- Religious counseling
- Reversal of an elective sterilization
- Rolfing therapy
- Routine eye care (Adult)
- Routine foot care
- Self-help programs
- Temporomandibular joint dysfunction
- Transplants of non-human/artificial organs
- Weight loss programs

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

- Chiropractic care (Up to 20 visits/year)
- Cosmetic surgery (Only if medically necessary or for certain reconstructive surgeries)
- Non-emergency care when traveling outside the United States. See **www.mhc.coop**

**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.HealthCare.gov or call 1-800-318-2596. 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 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 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: Montana Commissioner of Securities and Insurance, **(406) 444-2040.**

**Does this plan provide Minimum Essential Coverage?** **Yes**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**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:**

- Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Montana Health CO-OP, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 855-447-2900.
- Falls Sie oder jemand, dem Sie helfen, Fragen zum Montana Health CO-OP, haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 855-447-2900 an.
- 如果你，或你正在帮助，拥有约蒙大拿州卫生CO- OP的问题，你有没有成本，以获取帮助和信息在你的语言的权利。交谈口译员，请致电 855-447-2900.
- ご本人様、またはお客様の身の回りの方でも、Montana Health CO-OP についてご質問がございました ら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。 通訳とお話される場合、855-447-2900までお電話ください.
- Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Montana Health CO-OP, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 855-447-2900.
- Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Montana Health CO-OP, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 855-447-2900.
- Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Montana Health CO-OP, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 855-447-2900.
- 만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Montana Health CO-OP 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 855-447-2900 로 전화하십시오.
- إن كان لديك أو لدى شخص تساعده أسئلة بخصوص Montana Health CO-OP، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم اتصل بـ 855-447-2900.
- หากคุณ หรือคนที่คุณก าลังช่วยเหลือมีค าถามเกี่ยวกับ Montana Health CO-OP คุณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย พูดคุยกับล่าม โทร 855-447-2900.
- Hvis du, eller noen du hjelper, har spørsmål om Montana Health CO-OP, har du rett til å få hjelp og informasjon på ditt språk uten kostnad. For å snakke med en tolk, ring 855-447-2900.
- Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Montana Health CO-OP, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 855-447-2900.
- Якщо у Вас чи у когось, хто отримує Вашу допомогу, виникають питання про Montana Health CO-OP, у Вас є право отримати безкоштовну допомогу та інформацію на Вашій рідній мові. Щоб зв'язатись з перекладачем, задзвоніть на 855-447-2900.

- "Wann du hoscht en Froog, odder ebber, wu du helfscht, hot en Froog baut Montana Health CO-OP, hoscht du es Recht fer Hilf un Information in deinre eegne Schprooch griege, un die Hilf koschtet nix. Wann du mit me Interpreter schwetze witt, kannscht du 855-447-2900 uffrufe.
- Se tu o qualcuno che stai aiutando avete domande su Montana Health CO-OP, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 855-447-2900

*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*

## 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 *[cost sharing]* | $40 |
| Hospital (facility) *[cost sharing]* | 30% AD |
| Other *[cost sharing]* | 30% AD |

**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** | **$12,730** |
|---|---|

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $1,000 |
| Copayments | $80 |
| Coinsurance | $1,500 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Peg would pay is** | **$2,580** |

### 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 *[cost sharing]* | $40 |
| Hospital (facility) *[cost sharing]* | 30% AD |
| Other *[cost sharing]* | 30% AD |

**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** | **$7,389** |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $1,000 |
| Copayments | $100 |
| Coinsurance | $60 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Joe would pay is** | **$1,160** |

### Mia's Simple Fracture
(in-network emergency room visit and follow up care)

| | |
|---|---|
| The plan's overall deductible | $1,000 |
| Specialist *[cost sharing]* | $40 |
| Hospital (facility) *[cost sharing]* | 30% AD |
| Other *[cost sharing]* | 30% AD |

**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** | **$2,011** |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $1,000 |
| Copayments | $40 |
| Coinsurance | $60 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$2,000** |



The plan would be responsible for the other costs of these EXAMPLE covered services.