This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.mhc.coop or by calling (855) 447-2900.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Tier 1 network: **$850** person/ **$1,700** family. Tier 2 network: **$1,500** person/ **$3,000** family. Out-of-network: **$4,500** person / **$9,000** family.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**. The deductible doesn't apply to preventive care, pediatric vision, or copayments.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. Tier 1 network: **$5,000** person / **$10,000** family. Tier 2 network: **$5,000** person / family **$10,000**. Out-of-network: **$15,000** person / **$30,000** family.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. Any Deductible and Out of Pocket Maximum dollars from Tier 1 will be applied to Tier 2 Deductible and Out of Pocket Maximum respectively.
What is not included in the out–of–pocket limit?	Premiums, preventive care, balance-billed charges, and care not covered by the plan.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See **www.mhc.coop** or call **(855) 488-0622** for a list of participating providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about **excluded services**.

Questions: Call (855) 447-2900 or visit us at www.mhc.coop.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov/apps/glossary or call (855) 488-0622 to request a copy.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Tier 1 -- $25 copay before deductible Tier 2 – $25 copay after deductible	50% coinsurance after deductible	——————none——————
	Specialist visit	Tier 1 -- $35 copay before deductible Tier 2 – $35 copay after deductible	50% coinsurance after deductible	Chiropractic coverage is limited to 20 visits/year.
	Other practitioner office visit	Tier 1 -- $25 copay before deductible Tier 2 – $25 copay after deductible	50% coinsurance after deductible	——————none——————
	Preventive care/screening/immunization	Tier 1 – no charge Tier 2 – 30% coinsurance after deductible	50% coinsurance after deductible	——————none——————
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance after deductible	50% coinsurance after deductible	Diagnostic services, such as biopsies, are covered under the Surgical Services Benefit.
	Imaging (CT/PET scans, MRIs)	30% coinsurance after deductible	50% coinsurance after deductible	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.mhc.coop**.	Tier 0-Preventive drugs, Including contraceptives	$0	$0	You must pay an Ancillary Charge or provide a written statement from your attending physician if a medically necessary contraceptive outside of Tier 0 is prescribed.
	Tier 1-Preferred Generic drugs	20% per script for 30-day retail or 90-day mail order	20% per script for 30-day retail or 90-day mail order	——————none——————
	Tier 2-Preferred Brand drugs	25% per scrip for 30-day retail or 90-day mail order	25% per script for 30-day retail or 90-day mail order	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.
	Tier 3-Non-Preferred Brand and Generic drugs	45% per script for 30-day retail or 90-day mail order	45% per script for 30-day retail or 90-day mail order	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.
	Tier 4-Preferred Specialty drugs	45% per script for 30-day retail order	45% per script for 30-day retail order	Mail order not available
	Tier 5-Non-Preferred Specialty drug	45% per script for 30-day retail order	45% per script for 30-day retail order	Mail order not available
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance after deductible	50% coinsurance after deductible	——————none——————
	Physician/surgeon fees	30% coinsurance after deductible	50% coinsurance after deductible	——————none——————
If you need immediate medical	Emergency room services	$175 copay per visit	$175 copay per visit	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
attention	Emergency medical transportation	30% coinsurance after deductible	50% coinsurance after deductible	none
	Urgent care	30% coinsurance after deductible	50% coinsurance after deductible	none
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance after deductible	50% coinsurance after deductible	none
	Physician/surgeon fee	30% coinsurance after deductible	50% coinsurance after deductible	none
If you have mental health, behavioral health, or substance abuse needs	Office Visit	Tier 1 -- $25 copay before deductible Tier 2 – $25 copay after deductible	50% coinsurance after deductible	none
	Mental/Behavioral health outpatient services	Tier 1 -- $35 copay before deductible Tier 2 – $35 copay after deductible	50% coinsurance after deductible	none
	Mental/Behavioral health inpatient services	30% coinsurance after deductible	50% coinsurance after deductible	none
	Substance use disorder outpatient services	Tier 1 -- $35 copay before deductible Tier 2 – $35 copay after deductible	50% coinsurance after deductible	none
	Substance use disorder inpatient services	30% coinsurance after deductible	50% coinsurance after deductible	none
If you are pregnant	Prenatal and postnatal care	30% coinsurance after deductible	50% coinsurance after deductible	none
	Delivery and all inpatient services	30% coinsurance after deductible	50% coinsurance after deductible	none

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	30% coinsurance after deductible	50% coinsurance after deductible	Coverage is limited to 180 visits/year.
	Rehabilitation services- Inpatient/Outpatient	30% coinsurance after deductible	50% coinsurance after deductible	Limited to 20 visits/year for PT, OT, and ST combined
	Habilitation services- Inpatient/Outpatient	30% coinsurance after deductible	50% coinsurance after deductible	Limited to 20 visits/year for PT, OT, and ST combined
	Skilled nursing care	30% coinsurance after deductible	50% coinsurance after deductible	Coverage is limited to 60 visits/year
	Durable medical equipment	30% coinsurance after deductible	50% coinsurance after deductible	Preauthorization is required for original purchase or replacement of Durable Medical Equipment over $500
	Hospice service	30% coinsurance after deductible	50% coinsurance after deductible	——————none——————
If your child needs dental or eye care	Eye exam	No charge	25% coinsurance	Coverage is limited to one Vision Examination per Covered Dependent Child per Calendar Year.
	Glasses	No charge	25% coinsurance	Coverage is limited to one frame per Insured Dependent Child per Calendar Year.
	Dental check-up	Not covered	Not covered	——————none——————

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupressure
- Acupuncture
- Dental care and treatment
- Foot Care
- Hearing Aids
- Holistic Medicine
- Homeotherapy
- Marriage counseling
- Private duty nursing
- Religious counseling
- Reversal of an elective sterilization
- Rolfing therapy
- Self-help programs
- Stress management
- Transplants of non-human/artificial organs
- Vision Services (Adult)
- Weight reduction or weight control services

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care (Up to 20 visits/year)
- Cosmetic surgery must be: (a) incidental to or following surgery resulting from trauma, infection or other diseases of the involved part; and (b) because of congenital disease or anomaly of a Insured Dependent Child
- Emergency services only will be provided outside the United States. See **ww.mhc.coop**

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at **1-855-488-0622**. You may also contact your state insurance department at 1-800-721-3272.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 30% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, contact Customer Service at 1-855-488-0622. For questions about your rights, this notice, assistance, or you are unsatisfied with your appeal, you can contact: Idaho Department of Insurance, **1-800-721-3272**.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al **(855) 447-2900**.

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

- Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Mountain 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.
- 如果您，或是您正在協助的對象，有關於[插入 項目的名稱 Mountain Health CO-OP, 方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 [在此插入數字 855-447-2900.
- Ukoliko Vi ili neko kome Vi pomažete ima pitanje o Mountain Health CO-OP, imate pravo da besplatno dobijete pomoć i informacije na Vašem jeziku. Da biste razgovarali sa prevodiocem, nazovite 855-447-2900.
- 만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Mountain Health CO-OP, 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 855-447-2900로 전화하십시오.
- Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Mountain 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.
- لديك الحق في الحصول على المساعدة والمعلومات في لغتك دون أي تكلفة. للتحدث مع مترجم، والدعوة Mountain Health CO-OP، إذا كنت أنت أو شخص ما تحاول مساعدة، لديه تساؤلات حول 855-447-2900.
- Falls Sie oder jemand, dem Sie helfen, Fragen zum Mountain 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.
- Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Mountain 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.
- Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Mountain 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.
- Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Mountain 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.
- ご本人様、またはお客様の身の回りの方でも、Mountain 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。
- Dacă dumneavoastră sau persoana pe care o asistați aveți întrebări privind Mountain Health CO-OP, aveți dreptul de a obține gratuit ajutor și informații în limba dumneavoastră. Pentru a vorbi cu un interpret, sunați la 855-447-2990.
- To aan, malla goɗɗo mo mballata, e yama dow Mountain Health CO-OP, a woodi baawɗe heƀuki habaru malla wallireeki wolde maaɗa naa maa a yoƀii. Mbolda e pirtoowo, nodda 855-447-2900.
- اگر شما یا کسی که شما در حال تلاش برای کمک به، سوالات در مورد Mountain Health CO-OP، برای. شما حق دریافت کمک و اطلاعات به زبان خود را بدون هیچ هزینه داشته باشد صحبت با یک مترجم، 2900-447-855 پاسخ.
- Якщо у Вас чи у когось, хто отримує Вашу допомогу, виникають питання про Mountain 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.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $4,610
- **Patient pays** $2,930

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$850
Copays	$0
Coinsurance	$1,930
Limits or exclusions	$150
Total	**$2,930**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,430
- **Patient pays** $1,970

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$850
Copays	$220
Coinsurance	$820
Limits or exclusions	$80
Total	**$1,970**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.