




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](http://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 <a href="#">deductible</a> ?	For <a href="#">network providers</a> : \$800 individual / \$1,600 family; for <a href="#">out-of-network providers</a> : \$2,400 individual / \$4,800 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 deductibles for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	For <a href="#">network providers</a> \$5,750 individual / \$11,500 family; for <a href="#">out-of-network providers</a> \$17,250 individual / \$34,500 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> on 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.mhc.coop">www.mhc.coop</a> or call 1-855 447-2900 for information regarding <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 plan's <a href="#">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 provider's 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.
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> .

 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)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	\$30 <a href="#">copay</a> /office visit and 30% <a href="#">coinsurance</a> after <a href="#">deductible</a> for other outpatient services	50% coinsurance after <a href="#">deductible</a>	None
	<a href="#">Specialist</a> visit	\$40 <a href="#">copay</a> /office visit	50% coinsurance after <a href="#">deductible</a>	None
	<a href="#">Preventive care/screening/immunization</a>	No charge	50% coinsurance after <a href="#">deductible</a>	(Out of network-Well Child Care visits covered at 100% before deductible; Mammograms covered at a minimum payment of \$70 before deductible)
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	30% coinsurance after <a href="#">deductible</a>	50% coinsurance after <a href="#">deductible</a>	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% coinsurance after <a href="#">deductible</a>	50% coinsurance after <a href="#">deductible</a>	None
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.mhc.coop/Montana/explore-plans/drug-list/">www.mhc.coop/Montana/explore-plans/drug-list/</a>	Preferred Generic Drugs (Tier 1)	10% <a href="#">coinsurance</a> per drug /script for 31-day retail order or 90-day mail order	50% coinsurance after <a href="#">deductible</a>	None
	Non-Preferred Generic & Preferred Brand Drugs (Tier 2)	25% <a href="#">coinsurance</a> per drug /script for 31-day retail order or 90-day mail order	50% coinsurance after <a href="#">deductible</a>	If you choose a higher Tier drug when a lower Tier drug is available, you must pay an ancillary charge in addition to the <a href="#">deductible</a> and/or <a href="#">coinsurance</a> , as applicable.
	Non-Preferred brand Drugs (Tier 3)	35% <a href="#">coinsurance</a> per drug /script for 31-day retail order or 90-day mail order	50% coinsurance after <a href="#">deductible</a>	
	<a href="#">Specialty drugs</a>	45% <a href="#">coinsurance</a> per drug /script for 31-day retail or mail order	50% coinsurance after <a href="#">deductible</a>	In-Network coverage limited to CVS retail
Specialty Drugs (Tier 4)	90-day mail order not available			

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance after <a href="#">deductible</a>	50% coinsurance after <a href="#">deductible</a>	None
	Physician/surgeon fees	30% coinsurance after <a href="#">deductible</a>	50% coinsurance after <a href="#">deductible</a>	None
If you need immediate medical attention	<a href="#">Emergency room care</a>	30% coinsurance after <a href="#">deductible</a>	30% coinsurance after <a href="#">deductible</a>	None
	<a href="#">Emergency medical transportation</a>	30% coinsurance after <a href="#">deductible</a>	50% coinsurance after <a href="#">deductible</a>	None
	<a href="#">Urgent care</a>	\$40 <a href="#">copay</a> /office visit	50% coinsurance after <a href="#">deductible</a>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance after <a href="#">deductible</a>	50% coinsurance after <a href="#">deductible</a>	None
	Physician/surgeon fees	30% coinsurance after <a href="#">deductible</a>	50% coinsurance after <a href="#">deductible</a>	None
If you need mental health, behavioral health, or substance abuse services	<a href="#">Outpatient Services</a> Mental/Behavioral health Substance use disorder	\$30 <a href="#">copay</a> /office visit	50% coinsurance after <a href="#">deductible</a>	None
	<a href="#">Inpatient services</a> Mental/Behavioral health Substance use disorder	30% coinsurance after <a href="#">deductible</a>	50% coinsurance after <a href="#">deductible</a>	None
If you are pregnant	Office visits - Prenatal and postnatal care	30% coinsurance after <a href="#">deductible</a>	50% coinsurance after <a href="#">deductible</a>	None
	Childbirth/delivery professional services	30% coinsurance after <a href="#">deductible</a>	50% coinsurance after <a href="#">deductible</a>	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)	
	Childbirth/delivery facility services	30% coinsurance after <a href="#">deductible</a>	50% coinsurance after <a href="#">deductible</a>	None
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	30% coinsurance after <a href="#">deductible</a>	50% coinsurance after <a href="#">deductible</a>	180 visit limit/year
	<a href="#">Rehabilitation services</a>	30% coinsurance after <a href="#">deductible</a>	50% coinsurance after <a href="#">deductible</a>	None
	<a href="#">Habilitation services</a>	30% coinsurance after <a href="#">deductible</a>	50% coinsurance after <a href="#">deductible</a>	None
	<a href="#">Skilled nursing care</a>	30% coinsurance after <a href="#">deductible</a>	50% coinsurance after <a href="#">deductible</a>	60 day limit/year
	<a href="#">Durable medical equipment</a>	30% coinsurance after <a href="#">deductible</a>	50% coinsurance after <a href="#">deductible</a>	Preauthorization is required for original purchase or replacement of Durable Medical Equipment over \$500
	<a href="#">Hospice services</a>	30% coinsurance after <a href="#">deductible</a>	50% coinsurance	None
<b>If your child needs dental or eye care</b>	Children's eye exam	No charge	25% coinsurance	Coverage is limited to one Vision Examination per Covered Dependent Child per Calendar Year.
	Children's glasses	No charge	25% coinsurance	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:**

<b>Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or plan 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 endangered)</li><li>• Acupuncture</li><li>• Bariatric surgery</li><li>• Dental care and treatment</li><li>• Hearing Aids</li></ul>	<ul style="list-style-type: none"><li>• Long-term care</li><li>• Private-duty nursing</li><li>• Religious counseling</li><li>• Reversal of an elective sterilization</li><li>• Rolfing therapy</li><li>• Routine eye care (Adult)</li></ul>	<ul style="list-style-type: none"><li>• Routine foot care</li><li>• Self-help programs</li><li>• Temporomandibular joint dysfunction</li><li>• Transplants of non-human/artificial organs</li><li>• Weight loss programs</li></ul>
<b>Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)</b>		
<ul style="list-style-type: none"><li>• Chiropractic care (Up to 20 visits/year)</li></ul>	<ul style="list-style-type: none"><li>• Cosmetic surgery (Only if medically necessary or for certain reconstructive surgeries)</li></ul>	<ul style="list-style-type: none"><li>• Non-emergency care when traveling outside the United States. See <a href="http://www.mhc.coop">www.mhc.coop</a></li></ul>

**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](http://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](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 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.
- فلدیک الحق فی الحصول علی المساعدة والمعلومات. الضرورية بلغتك من دون اية تكلفة. للتحدث، Montana Health CO-OP، إن كان لديك أو لدى شخص تساعدك أسئلة بخصوص 2900-447-855 مع مترجم اتصل بـ.
- หากคุณ หรือคนที่ถูกก ำลังช่วยเหลือหรือมีค ำถามเกี่ยวกับ 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 helpscht, 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](#) \$800
- [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*)

<b>Total Example Cost</b>	<b>\$12,731</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
Deductibles	\$800
Copayments	\$60
Coinsurance	\$3,724
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$4644</b>

**Managing Joe's type 2 Diabetes**  
(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$800
- [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*)

<b>Total Example Cost</b>	<b>\$7,389</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
Deductibles	\$800
Copayments	\$320
Coinsurance	\$1,522
<i>What isn't covered</i>	
Limits or exclusions	\$55
<b>The total Joe would pay is</b>	<b>\$2,697</b>

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

- The [plan's](#) overall [deductible](#) \$800
- [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*)

<b>Total Example Cost</b>	<b>\$1925</b>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
Deductibles	\$800
Copayments	\$280
Coinsurance	\$425
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,505</b>

These numbers assume the patient received care from an IHCP provider or with IHCP referral at a non-IHCP. If you receive care from a non-IHCP provider without a referral from an IHCP your costs may be higher.