**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: **$4,000** individual / **$8,000** family; for out-of-network providers: **$12,000** individual / **$24,000** 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?** | For network providers **$8,150** individual / $**16,300** family; for out-of-network providers $**24,450** individual / $**48,900** 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 | $40 for first 10 visits, before deductible; then $40 copay/office visit after deductible | 60% coinsurance after deductible | None |
| | Specialist visit | $65 copay/office visit after deductible | 60% coinsurance after deductible | None |
| | Preventive care/screening/ immunization | No charge | 60% coinsurance 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) | 40% coinsurance after deductible | 60% coinsurance 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) | 40% coinsurance after deductible | 60% coinsurance 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) | 20% coinsurance per drug /script for 31-day retail order or 90-day mail order | 50% coinsurance after deductible | None |
| | Non-Preferred Generic & Preferred Brand Drugs (Tier 2) | 30% coinsurance per drug /script for 31-day retail order or 90-day mail order | 50% coinsurance 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) | 40% coinsurance per drug /script for 31-day retail order or 90-day mail order | 50% coinsurance after deductible | |
| | Specialty drugs<br><br>Specialty Drugs (Tier 4) | 50% coinsurance per drug /script for 31-day retail or mail order | 50% coinsurance after deductible | In-Network coverage limited to select pharmacies. |


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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) | |
| | | 90-day mail order not available | | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 40% coinsurance after deductible | 60% coinsurance after deductible | None |
| | Physician/surgeon fees | 40% coinsurance after deductible | 60% coinsurance after deductible | None |
| **If you need immediate medical attention** | Emergency room care | 40% coinsurance after deductible | 40% coinsurance after deductible | None |
| | Emergency medical transportation | 40% coinsurance after deductible | 60% coinsurance after deductible | None |
| | Urgent care | $120 copay after deductible | 60% coinsurance after deductible | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 40% coinsurance after deductible | 60% coinsurance after deductible | None |
| | Physician/surgeon fees | 40% coinsurance after deductible | 60% coinsurance after deductible | None |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient Services<br>Mental/Behavioral health<br>Substance use disorder | $40 for first 10 visits, before deductible; then $40 copay/office visit after deductible | 60% coinsurance after deductible | None |
| | Inpatient services<br>Mental/Behavioral health<br>Substance use disorder | 40% coinsurance after deductible | 60% coinsurance after deductible | None |
| **If you are pregnant** | Office visits - Prenatal and postnatal care | 40% coinsurance after deductible | 60% coinsurance 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) | |
| | Childbirth/delivery professional services | 40% coinsurance after deductible | 60% coinsurance after deductible | None |
| | Childbirth/delivery facility services | 40% coinsurance after deductible | 60% coinsurance after deductible | None |
| **If you need help recovering or have other special health needs** | Home health care | 40% coinsurance after deductible | 60% coinsurance after deductible | 180 visit limit/year |
| | Rehabilitation services | $65 copay/office visit after deductible | 60% coinsurance after deductible | None |
| | Habilitation services | 40% coinsurance after deductible | 60% coinsurance after deductible | None |
| | Skilled nursing care | 40% coinsurance after deductible | 60% coinsurance after deductible | 60 day limit/year |
| | Durable medical equipment | 40% coinsurance after deductible | 60% coinsurance after deductible | Preauthorization is required for original purchase or replacement of Durable Medical Equipment over $500 |
| | Hospice services | 40% coinsurance after deductible | 60% coinsurance after deductible | None |
| **If your child needs dental or eye care** | 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 |


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## 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)
- 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)
- 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)
- Acupuncture (Up to 20 visits/year)
- Cosmetic surgery (Only if medically necessary or for certain reconstructive surgeries)
- Routine foot care provided for Members with Diabetes
- 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:**
SPANISH: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-447-2900.

CHINESE: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-447-2900.

SERBO-CROATION: U ovom obavještenju su sadržane važne informacije. U ovom obavještenju su sadržane važne informacije o Vašoj prijavi ili osiguranju preko MHC. Pogledajte nalaze li se u ovom obavještenju nekiključni datumi. Možda ćete morati poduzeti određenje radnje u datom roku kako biste i dalje zadržali svoje osiguranje ili pomoć pri plaćanju.Imate pravo da ove informacije, kao i pomoć, dobijete besplatno na svom jeziku. Nazovite 1-855-447-2900.

KOREAN: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-xxx-xxx-xxxx (TTY: 1-xxx-xxx-xxxx)번으로 전화해 주십시오. 1-855-447-2900

VIETNAMESE: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-447-2900.

ARABIC:(رقم هاتف 855-447-2900ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1- يحوي هذا ا؟شعار معلومات هامة. يحوي هذا ا؟شعار معلومات مهمة بخصوص طلبك للحصول على التغطية من خ؟ل ابحث عن التواريخ الصم والبكم: 1- 855-447-2900.)

GERMAN: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-447-2900.

TAGALOG: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-447-2900.

RUSSIAN: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-447-2900.

FRENCH: ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-447-2900.

ITALIAN: ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-447-2900.

JAPANESE: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-855-447-2900（TTY:1-855-447-2900）まで、お電話にてご連絡ください。

THAI: เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-855-447-2900 (TTY: 1-855-447-2900).

ROMANIAN: ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-855-447-2900.

SUDANIC-FULFULDE: Anndinoore nde'e e woodi habaru kimminiiɗum. TAnndinoore nde'e e woodi habaru kimminiiɗum dow ɗereewol tefal maaɗamaaɗa malla ko yaali dow laawol MHC. Maanda nyalaaɗe lewru nder anndinoorende'e. Teema a giɗeteeɗo ngaɗa goɗɗum bako goɗɗe nyalaaɗe ngam ko yaali njamu maaɗa malla walla dow njobdi. Hakke maaɗa annda habaru ngu'u ewalliinde nder wolde maaɗa naa maa a yobii. Noddu 1-855-447-2900.

UKRAINIAN: УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-855-447-2900 (телетайп: 1-855-447-2900).

NEPALI: ध्यान दिनुहोस्: तपाईले नेपाली बोल्नुहुन्छ भने तपाईको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-855-447-2900 (टिटिवाइ: 1-855-447-2900)

SERBO-CROATIAN: OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-855-447-2900 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 1-855-447-2900).

BANTU: ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona 1-855-447-2900 (TTY: 1-855-447-2900).

FARSI: توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-855-447-2900 (TTY: 1-855-447-2900) تماس بگیرید.

NORWEGIAN: MERK: Hvis du snakker norsk, er gratis språkassistansetjenester tilgjengelige for deg. Ring 1-855-447-2900.

PENNSYLVANIA DUTCH: Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-855-447-2900.

*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 | $4000 |
| Specialist *[cost sharing]* | $65AD |
| Hospital (facility) *[cost sharing]* | 40%AD |
| Other *[cost sharing]* | 40%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 | $3190 |
| Copayments | $0 |
| Coinsurance | $4959 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$8209** |

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

| | |
|---|---|
| The plan's overall deductible | $4000 |
| Specialist *[cost sharing]* | $65AD |
| Hospital (facility) *[cost sharing]* | 40%AD |
| Other *[cost sharing]* | 40%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 | $1731 |
| Copayments | $450 |
| Coinsurance | $1954 |
| *What isn't covered* | |
| Limits or exclusions | $55 |
| **The total Joe would pay is** | **$4135** |

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

| | |
|---|---|
| The plan's overall deductible | $4000 |
| Specialist *[cost sharing]* | $65AD |
| Hospital (facility) *[cost sharing]* | 40%AD |
| Other *[cost sharing]* | 40%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** | **$1979** |

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

| *Cost Sharing* | |
|---|---|
| Deductibles | $1077 |
| Copayments | $195 |
| Coinsurance | $653 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1925** |