




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:
<b>What is the overall <a href="#">deductible</a>?</b>	For <a href="#">network providers</a> : <b>\$750</b> individual / <b>\$1,500</b> family; for <a href="#">out-of-network providers</a> : <b>\$2,250</b> individual / <b>\$4,500</b> 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> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	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> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	No	You don't have to meet deductibles for specific services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	For <a href="#">network providers</a> <b>\$5,750</b> individual / <b>\$11,500</b> family; for <a href="#">out-of-network providers</a> <b>\$17,250</b> individual / <b>\$34,500</b> 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.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	<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> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes. See <a href="http://www.mhc.coop">www.mhc.coop</a> or call <b>1-855 447-2900</b> 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.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	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	\$35 <a href="#">copay</a> /office visit and 30% <a href="#">coinsurance</a> after <a href="#">deductible</a> for other outpatient services	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None
	<a href="#">Specialist</a> visit	\$40 <a href="#">copay</a> /office visit	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None
	<a href="#">Preventive care/screening/immunization</a>	No charge	50% <a href="#">coinsurance</a> 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% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> 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% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> 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% <a href="#">coinsurance</a> 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% <a href="#">coinsurance</a> 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% <a href="#">coinsurance</a> 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% <a href="#">coinsurance</a> after <a href="#">deductible</a>	In-Network coverage limited to select pharmacies.
	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)	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None
	Physician/surgeon fees	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None
	<a href="#">Emergency medical transportation</a>	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None
	<a href="#">Urgent care</a>	\$105 <a href="#">copay</a> /visit	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None
	Physician/surgeon fees	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None
<b>If you need mental health, behavioral health, or substance abuse services</b>	<a href="#">Outpatient Services</a> Mental/Behavioral health Substance use disorder	\$35 <a href="#">copay</a> /office visit	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None
	<a href="#">Inpatient services</a> Mental/Behavioral health Substance use disorder	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None
<b>If you are pregnant</b>	Office visits - Prenatal and postnatal care	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None
	Childbirth/delivery professional services	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> 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% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> 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% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	180 visit limit/year
	<a href="#">Rehabilitation services</a>	\$40 <a href="#">copay</a> /office visit	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None
	<a href="#">Habilitation services</a>	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None
	<a href="#">Skilled nursing care</a>	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	60 day limit/year
	<a href="#">Durable medical equipment</a>	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> 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% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None
<b>If your child needs dental or eye care</b>	Children's eye exam	No charge	25% <a href="#">coinsurance</a>	Coverage is limited to one Vision Examination per Covered Dependent Child per Calendar Year.
	Children's glasses	No charge	25% <a href="#">coinsurance</a>	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) | • Long-term care                        | • Self-help programs                         |
| • Bariatric surgery   | • Private-duty nursing                  | • Temporomandibular joint dysfunction        |
| • Dental care and treatment   | • Religious counseling                  | • Transplants of non-human/artificial organs |
| • Hearing Aids  | • Reversal of an elective sterilization | • Weight loss programs                       |
|   | • Rolfing therapy                       |  |
|   | • Routine eye care (Adult)              |  |

**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 <a href="http://www.mhc.coop">www.mhc.coop</a> |
| • Acupuncture (Up to 12 visits/year)       | • Routine foot care provided for Members with Diabetes                                   |   |

**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:

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 855-447-2900 ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1- يحوي هذا إشعار معلومات هامة. يحوي هذا إشعار معلومات مهمة بخصوص طلبك للحصول على التغطية من خ اجل ابحت عن التواريخ: 855-447-2900/الضم واليكم: 1-)

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: หากคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี 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 kimminiidum. TAnndinoore nde'e e woodi habaru kimminiidum dow dereewol tefal maadamaada malla ko yaali dow laawol MHC. Maanda nyalaade lewru nder anndinoorende'e. Teema a gideteedo ngada goddum bako godde nyalaade ngam ko yaali njamu maada malla walla dow njobdi. Hakke maada annda habaru ngu'u ewalliinde nder wolde maada 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: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-855-447-2900 (टिडिवाइ: 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).

MHC-5100-GLD-SBC

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146  
Released on April 6, 2016

**Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services**  
**Montana Health CO-OP: CONNECTED CARE GOLD**

**Coverage Period: 01/01/2020 – 12/31/2020**  
**Coverage for: Individual/Family | Plan Type: PPO**

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

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

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)] schwetzsch, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-855-447-2900.

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*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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$750
■ <a href="#">Specialist</a> [ <i>cost sharing</i> ]	\$40
■ Hospital (facility) [ <i>cost sharing</i> ]	30%AD
■ Other [ <i>cost sharing</i> ]	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>\$12,732</b>
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#### In this example, Peg would pay:

Cost Sharing	
Deductibles	\$750
Copayments	\$70
Coinsurance	\$3,724
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$4604</b>

### Managing Joe's type 2 Diabetes

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$750
■ <a href="#">Specialist</a> [ <i>cost sharing</i> ]	\$40
■ Hospital (facility) [ <i>cost sharing</i> ]	30%AD
■ Other [ <i>cost sharing</i> ]	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>\$7,390</b>
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#### In this example, Joe would pay:

Cost Sharing	
Deductibles	\$750
Copayments	\$360
Coinsurance	\$1,522
What isn't covered	
Limits or exclusions	\$55
<b>The total Joe would pay is</b>	<b>\$2,687</b>

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$750
■ <a href="#">Specialist</a> [ <i>cost sharing</i> ]	\$40
■ Hospital (facility) [ <i>cost sharing</i> ]	30%AD
■ Other [ <i>cost sharing</i> ]	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>\$1926</b>
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#### In this example, Mia would pay:

Cost Sharing	
Deductibles	\$750
Copayments	\$120
Coinsurance	\$490
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,360</b>