




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.mountainhealth.coop or call 855-447-2900. 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 www.healthcare.gov/glossary or call 1-800-318-2596 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|--|---|
| What is the overall deductible ? | \$0 | See the Common Medical Events chart below for your costs for services this plan covers. |
| Are there services covered before you meet your deductible ? | Yes. | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. |
| 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 ? | Not Applicable | This plan does not have an out-of-pocket limit on your expenses. |
| What is not included in the out-of-pocket limit ? | Not Applicable | This plan does not have an out-of-pocket limit on your expenses. |
| Will you pay less if you use a network provider ? | Yes. See www.mountainhealth.coop/find-a-doctor or call 1-855-447-2900 for a list of 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 . |

 All [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 |
|--|--|---|--|---|
| | | Indian Health Care Provider (IHCP) (You will pay the least) | Non-IHCP 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 | No charge | No charge | None |
| | Specialist visit | No charge | No charge | None |
| | Preventive care/screening/immunization | No charge | No charge | Frequency limitations apply. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. |
| If you have a test | Diagnostic test (x-ray, blood work) | No charge | No charge | Preauthorization may be required. See section 6 of the policy document for more information. |
| | Imaging (CT/PET scans, MRIs) | No charge | No charge | |
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.mountainhealth.coop/pharmacy . | Generic drugs | Retail: No charge Mail Order: No charge | Retail: No charge Mail Order: No charge | Covers up to a 30-day supply (retail subscription); 30-90 day supply (mail order prescription). |
| | Preferred brand drugs | Retail: No charge Mail Order: No charge | Retail: No charge Mail Order: No charge | Covers up to a 30-day supply (retail subscription); 30-90 day supply (mail order prescription). If you choose a higher Tier drug when a lower Tier drug is available, you may be subject to additional member responsibility. |
| | Non-preferred brand drugs | Retail: No charge Mail Order: No charge | Retail: No charge Mail Order: No charge | |
| | Specialty drugs | No charge | No charge | Covers up to a 30-day supply (retail subscription); mail order not available. Provider network limited to select pharmacies. |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | No charge | No charge | Preauthorization may be required. See section 6 of the policy document for more information. |
| | Physician/surgeon fees | No charge | No charge | |
| If you need immediate medical attention | Emergency room care | No charge | No charge | None |
| | Emergency medical transportation | No charge | No charge | |

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.mountainhealth.coop/plans/.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|--|
| | | Indian Health Care Provider (IHCP) (You will pay the least) | Non-IHCP Provider (You will pay the most) | |
| | Urgent care | No charge | No charge | |
| If you have a hospital stay | Facility fee (e.g., hospital room) | No charge | No charge | Preauthorization may be required. See section 6 of the policy document for more information. |
| | Physician/surgeon fees | No charge | No charge | |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | No charge | No charge | Preauthorization may be required. See section 6 of the policy document for more information. |
| | Inpatient services | No charge | No charge | |
| If you are pregnant | Office visits | No charge | No charge | Cost sharing does not apply for preventive services . Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Preauthorization may be required. See policy document for more information. |
| | Childbirth/delivery professional services | No charge | No charge | |
| | Childbirth/delivery facility services | No charge | No charge | |
| If you need help recovering or have other special health needs | Home health care | No charge | No charge | 180 visits/year. Preauthorization may be required. See policy document for more information. |
| | Rehabilitation services | No charge | No charge | Preauthorization may be required. See section 6 of the policy document for more information. |
| | Habilitation services | No charge | No charge | Preauthorization may be required. See section 6 of the policy document for more information. |
| | Skilled nursing care | No charge | No charge | 60 days/year. Preauthorization may be required. See section 6 of the policy document for more information. |
| | Durable medical equipment | No charge | No charge | Preauthorization may be required. See section 6 of the policy document for more information. |
| | Hospice services | No charge | No charge | Preauthorization may be required. See section 6 of the policy document for more information. |

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| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|--|----------------------------|---|---|--|
| | | Indian Health Care Provider (IHCP) (You will pay the least) | Non-IHCP Provider (You will pay the most) | |
| If your child needs dental or eye care | Children's eye exam | No charge | No charge | Coverage is limited to one exam/year for those under age 19. |
| | Children's glasses | No charge | No charge | Coverage is limited to one pair of eyeglasses/year for those under age 19. |
| | Children's dental check-up | Not Covered | Not Covered | Not Covered |

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 .) | | |
|---|---|--|
| <ul style="list-style-type: none"> Abortion - except in the case of rape, incest, or when the life of the mother is in danger Bariatric Surgery | <ul style="list-style-type: none"> Dental Care (Child) Hearing Aids (Adult) | <ul style="list-style-type: none"> Long Term Care Private-duty nursing Weight loss programs |

| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.) | | |
|--|--|---|
| <ul style="list-style-type: none"> Acupuncture - Up to 12 visits/year Chiropractic Care - Up to 20 visits/year Cosmetic surgery - Only if medically necessary for certain reconstructive surgeries Dental Care (Adult) - up to \$100 limit | <ul style="list-style-type: none"> Hearing Aids (Child) - Preauthorization required Infertility treatment, except invitro fertilization Non-emergency care when traveling outside the United States. See www.mountainhealth.coop/plans/ for more information. | <ul style="list-style-type: none"> Routine eye care (Adult) - up to \$60 limit Routine foot care provided to a member 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: Mountain Health Co-Op at 1-855-447-2900. State insurance department at 1-866-444-3272 or <https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa>. State consumer assistance program at <https://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants>. 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 on how 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: www.mountainhealth.coop or call 1-855-447-2900.

Does this plan provide Minimum Essential Coverage? Yes

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.mountainhealth.coop/plans/.

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](#).

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 [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$0
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 0%

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 | \$12,700 |
|---------------------------|-----------------|

In this example, Peg would pay:

| Cost Sharing | |
|-----------------------------------|------------|
| Deductibles | \$0 |
| Copayments | \$0 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or exclusions | \$0 |
| The total Peg would pay is | \$0 |

Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$0
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 0%

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 | \$5,600 |
|---------------------------|----------------|

In this example, Joe would pay:

| Cost Sharing | |
|-----------------------------------|------------|
| Deductibles | \$0 |
| Copayments | \$0 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or exclusions | \$0 |
| The total Joe would pay is | \$0 |

Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$0
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 0%

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 | \$2,800 |
|---------------------------|----------------|

In this example, Mia would pay:

| Cost Sharing | |
|-----------------------------------|------------|
| Deductibles | \$0 |
| Copayments | \$0 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$0 |

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

