



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](http://www.mountainhealth.coop) or call 800-299-6080. 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](http://www.healthcare.gov/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> ?                                | \$0                                                                                                                                                                              | See the Common Medical Events chart below for your costs for services this <a href="#">plan</a> covers.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | Yes.                                                                                                                                                                             | 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.                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| Are there other <a href="#">deductibles</a> for specific services?              | No                                                                                                                                                                               | You don't have to meet <a href="#">deductibles</a> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | Not Applicable                                                                                                                                                                   | This <a href="#">plan</a> does not have an <a href="#">out-of-pocket limit</a> on your expenses.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| What is not included in the <a href="#">out-of-pocket limit</a> ?               | Not Applicable                                                                                                                                                                   | This <a href="#">plan</a> does not have an <a href="#">out-of-pocket limit</a> on your expenses.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| Will you pay less if you use a <a href="#">network provider</a> ?               | Yes. See <a href="http://www.mountainhealth.coop/find-a-doctor">www.mountainhealth.coop/find-a-doctor</a> or call 800-299-6080 for a list of <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 <a href="#">plan's 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 <a href="#">provider's</a> 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> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |

 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 <a href="#">provider's</a> office or clinic                                                                                                                                                             | Primary care visit to treat an injury or illness       | No charge                                                   | No charge                                  | None                                                                                                                                                                                                                          |
|                                                                                                                                                                                                                                    | <a href="#">Specialist</a> visit                       | No charge                                                   | No charge                                  | None                                                                                                                                                                                                                          |
|                                                                                                                                                                                                                                    | <a href="#">Preventive care/screening/immunization</a> | No charge                                                   | No charge                                  | Frequency limitations apply. You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.        |
| If you have a test                                                                                                                                                                                                                 | <a href="#">Diagnostic test</a> (x-ray, blood work)    | No charge                                                   | No charge                                  | * <a href="#">Preauthorization</a> 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<br>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.mountainhealth.coop/pharmacy">www.mountainhealth.coop/pharmacy</a> . | Generic drugs                                          | Retail: No charge<br>Mail Order: No charge                  | Retail: No charge<br>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<br>Mail Order: No charge                  | Retail: No charge<br>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<br>Mail Order: No charge                  | Retail: No charge<br>Mail Order: No charge |                                                                                                                                                                                                                               |
|                                                                                                                                                                                                                                    | <a href="#">Specialty drugs</a>                        | No charge                                                   | No charge                                  | Covers up to a 30-day supply (retail subscription); mail order not available. <a href="#">Provider network</a> limited to select pharmacies.                                                                                  |
| If you have outpatient surgery                                                                                                                                                                                                     | Facility fee (e.g., ambulatory surgery center)         | No charge                                                   | No charge                                  | * <a href="#">Preauthorization</a> 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                                                                                                                                                                                            | <a href="#">Emergency room care</a>                    | No charge                                                   | No charge                                  | None                                                                                                                                                                                                                          |
|                                                                                                                                                                                                                                    | <a href="#">Emergency medical transportation</a>       | No charge                                                   | No charge                                  |                                                                                                                                                                                                                               |

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.mountainhealth.coop/plans/](http://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) |                                                                                                                                                                                                                                                                                                                                                                     |
|                                                                           | <a href="#">Urgent care</a>               | No charge                                                   | No charge                                 |                                                                                                                                                                                                                                                                                                                                                                     |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)        | No charge                                                   | No charge                                 | * <a href="#">Preauthorization</a> 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                                 | * <a href="#">Preauthorization</a> 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                                 | <a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of services, a <a href="#">coinsurance</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).<br>* <a href="#">Preauthorization</a> 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            | <a href="#">Home health care</a>          | No charge                                                   | No charge                                 | 180 visits/year. * <a href="#">Preauthorization</a> may be required. See policy document for more information.                                                                                                                                                                                                                                                      |
|                                                                           | <a href="#">Rehabilitation services</a>   | No charge                                                   | No charge                                 | * <a href="#">Preauthorization</a> may be required. See section 6 of the policy document for more information.                                                                                                                                                                                                                                                      |
|                                                                           | <a href="#">Habilitation services</a>     | No charge                                                   | No charge                                 | <a href="#">Preauthorization</a> may be required. See section 6 of the policy document for more information.                                                                                                                                                                                                                                                        |
|                                                                           | <a href="#">Skilled nursing care</a>      | No charge                                                   | No charge                                 | 60 days/year. * <a href="#">Preauthorization</a> may be required. See section 6 of the policy document for more information.                                                                                                                                                                                                                                        |
|                                                                           | <a href="#">Durable medical equipment</a> | No charge                                                   | No charge                                 | * <a href="#">Preauthorization</a> may be required. See section 6 of the policy document for more information.                                                                                                                                                                                                                                                      |
|                                                                           | <a href="#">Hospice services</a>          | No charge                                                   | No charge                                 | * <a href="#">Preauthorization</a> may be required. See section 6 of the policy document for more information.                                                                                                                                                                                                                                                      |

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.mountainhealth.coop/plans/](http://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) |                                                                            |
| 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 <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .) |                                                                                                                                                                           |                                                                                                                              |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------|--|
| <ul style="list-style-type: none"> <li>Abortion - except in the case of rape, incest, or when the life of the mother is in danger</li> <li>Bariatric surgery</li> </ul>                           | <ul style="list-style-type: none"> <li>Dental care (Child)</li> <li>Hearing aids (Adult)</li> <li>Non-emergency care when traveling outside the United States.</li> </ul> | <ul style="list-style-type: none"> <li>Long term care</li> <li>Private-duty nursing</li> <li>Weight loss programs</li> </ul> |  |

| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)                                                                                                                                         |                                                                                                                                                                                                                              |                                                                                                                                                             |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| <ul style="list-style-type: none"> <li>Acupuncture - Up to 12 visits/year</li> <li>Chiropractic care - Up to 20 visits/year</li> <li>Cosmetic surgery - Only if medically necessary for certain reconstructive surgeries</li> <li>Dental care (Adult) - up to \$100 limit</li> </ul> | <ul style="list-style-type: none"> <li>Hearing aids (Child) - <a href="#">Preauthorization</a> required: under age 19, one per ear every three years</li> <li>Infertility treatment, except invitro fertilization</li> </ul> | <ul style="list-style-type: none"> <li>Routine eye care (Adult) - up to \$60 limit</li> <li>Routine foot care provided to a member with Diabetes</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: Mountain Health Co-Op at 1-855-447-2900/800-299-6080 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](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 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](http://www.mountainhealth.coop) or call 800-299-6080.

#### 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](#).

#### 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](#).

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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> | \$0 |
| ■ <a href="#">Specialist copayment</a>                          | \$0 |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 0%  |
| ■ Other <a href="#">coinsurance</a>                             | 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*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,700</b> |
|---------------------------|-----------------|

In this example, Peg would pay:

| Cost Sharing                      |            |
|-----------------------------------|------------|
| <a href="#">Deductibles</a>       | \$0        |
| <a href="#">Copayments</a>        | \$0        |
| <a href="#">Coinsurance</a>       | \$0        |
| What isn't covered                |            |
| Limits or exclusions              | \$0        |
| <b>The total Peg would pay is</b> | <b>\$0</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> | \$0 |
| ■ <a href="#">Specialist copayment</a>                          | \$0 |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 0%  |
| ■ Other <a href="#">coinsurance</a>                             | 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$5,600</b> |
|---------------------------|----------------|

In this example, Joe would pay:

| Cost Sharing                      |            |
|-----------------------------------|------------|
| <a href="#">Deductibles</a>       | \$0        |
| <a href="#">Copayments</a>        | \$0        |
| <a href="#">Coinsurance</a>       | \$0        |
| What isn't covered                |            |
| Limits or exclusions              | \$0        |
| <b>The total Joe would pay is</b> | <b>\$0</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> | \$0 |
| ■ <a href="#">Specialist copayment</a>                          | \$0 |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 0%  |
| ■ Other <a href="#">coinsurance</a>                             | 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,800</b> |
|---------------------------|----------------|

In this example, Mia would pay:

| Cost Sharing                      |            |
|-----------------------------------|------------|
| <a href="#">Deductibles</a>       | \$0        |
| <a href="#">Copayments</a>        | \$0        |
| <a href="#">Coinsurance</a>       | \$0        |
| What isn't covered                |            |
| Limits or exclusions              | \$0        |
| <b>The total Mia would pay is</b> | <b>\$0</b> |

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