




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 <https://www.mountainhealth.coop/individual-plan-documents-wy> 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 [www.healthcare.gov/sbc-glossary/](http://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> : \$7,200 individual \$14,400 family ; for <a href="#">out-of-network providers</a> : \$21,600 individual \$43,200 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> 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 <a href="#">deductibles</a> 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> : \$8,150 individual \$16,300 family; for <a href="#">out-of-network providers</a> : \$24,450 individual \$48,900 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="https://www.mountainhealth.coop/fin-d-a-doctor">https://www.mountainhealth.coop/fin-d-a-doctor</a> or call 1-855 447-2900 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 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</b>	No	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

Important Questions	Answers	Why This Matters:
see a <a href="#">specialist</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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$60 <a href="#">copay</a> /visit; <a href="#">deductible</a> does not apply.	70% <a href="#">coinsurance</a>	If an <a href="#">out-of-network provider</a> charges more than the <a href="#">allowed amount</a> , you may have to pay the difference ( <a href="#">balance billing</a> ). If an <a href="#">out-of-network provider</a> charges more than the <a href="#">allowed amount</a> , you may have to pay the difference ( <a href="#">balance billing</a> ). 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.
	<a href="#">Specialist</a> visit	70% <a href="#">coinsurance</a>	70% <a href="#">coinsurance</a>	
	<a href="#">Preventive care/screening/immunization</a>	No Charge	70% <a href="#">coinsurance</a>	
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	70% <a href="#">coinsurance</a>	70% <a href="#">coinsurance</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)	70% <a href="#">coinsurance</a>	70% <a href="#">coinsurance</a>	
<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="https://www.mountainhealth.coop/pharmacy">https://www.mountainhealth.coop/pharmacy</a>	Generic drugs	Retail: \$15 <a href="#">copay</a> /prescription; Mail Order: \$30 <a href="#">copay</a> /prescription;	70% <a href="#">coinsurance</a>	31-day supply retail 90-day supply mail-order.
	Preferred brand drugs	Retail: \$125 <a href="#">copay</a> /prescription Mail Order: \$250 <a href="#">copay</a> /prescription;	70% <a href="#">coinsurance</a>	31-day supply retail 90-day supply mail-order. If you choose a higher Tier drug when 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	Retail: \$160 <a href="#">copay</a> /prescription; <a href="#">deductible</a> does not apply. Mail Order: \$320 <a href="#">copay</a>	70% <a href="#">coinsurance</a>	31-day supply retail 90-day supply mail-order. If you choose a higher Tier drug when a lower Tier drug is available, you must pay an ancillary charge in addition to the

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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)	
		/prescription; <a href="#">deductible</a> does not apply.		<a href="#">deductible</a> and/or <a href="#">coinsurance</a> , as applicable.
	<a href="#">Specialty drugs</a>	Retail: \$185 <a href="#">copay</a> /prescription;	70% <a href="#">coinsurance</a>	31-day supply Mail order not available. In-Network coverage limited to select pharmacies.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	60% <a href="#">coinsurance</a>	70% <a href="#">coinsurance</a>	If an <a href="#">out-of-network provider</a> charges more than the <a href="#">allowed amount</a> , you may have to pay the difference ( <a href="#">balance billing</a> ).
	Physician/surgeon fees	60% <a href="#">coinsurance</a>	70% <a href="#">coinsurance</a>	
If you need immediate medical attention	<a href="#">Emergency room care</a>	70% <a href="#">coinsurance</a>	70% <a href="#">coinsurance</a>	If an <a href="#">out-of-network provider</a> charges more than the <a href="#">allowed amount</a> , you may have to pay the difference ( <a href="#">balance billing</a> ).
	<a href="#">Emergency medical transportation</a>	70% <a href="#">coinsurance</a>	70% <a href="#">coinsurance</a>	
	<a href="#">Urgent care</a>	70% <a href="#">coinsurance</a>	70% <a href="#">coinsurance</a>	
If you have a hospital stay	Facility fee (e.g., hospital room)	60% <a href="#">coinsurance</a>	70% <a href="#">coinsurance</a>	If an <a href="#">out-of-network provider</a> charges more than the <a href="#">allowed amount</a> , you may have to pay the difference ( <a href="#">balance billing</a> ).
	Physician/surgeon fees	60% <a href="#">coinsurance</a>	70% <a href="#">coinsurance</a>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$60 copay /visit;	70% <a href="#">coinsurance</a>	If an <a href="#">out-of-network provider</a> charges more than the <a href="#">allowed amount</a> , you may have to pay the difference ( <a href="#">balance billing</a> ).
	Inpatient services		70% <a href="#">coinsurance</a>	
If you are pregnant	Office visits	No Charge	No Charge	Included in delivery
	Childbirth/delivery professional services	60% <a href="#">coinsurance</a>	70% <a href="#">coinsurance</a>	If an <a href="#">out-of-network provider</a> charges more than the <a href="#">allowed amount</a> , you may have to pay the difference ( <a href="#">balance billing</a> ). <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).
	Childbirth/delivery facility services	60% <a href="#">coinsurance</a>	70% <a href="#">coinsurance</a>	
If you need help recovering or have	<a href="#">Home health care</a>	60% <a href="#">coinsurance</a>	70% <a href="#">coinsurance</a>	If an <a href="#">out-of-network provider</a> charges more than the <a href="#">allowed amount</a> , you may have to pay the difference ( <a href="#">balance billing</a> ).

\* For more information about limitations and exceptions, see the [plan](#) or policy document at <https://www.mountainhealth.coop/individual-plan-documents-wy>

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>other special health needs</b>	<a href="#">Rehabilitation services</a>	70% <a href="#">coinsurance</a>	70% <a href="#">coinsurance</a>	40 visit limit/year each for physical, occupational, and speech therapy. If an <a href="#">out-of-network provider</a> charges more than the <a href="#">allowed amount</a> , you may have to pay the difference ( <a href="#">balance billing</a> ).
	<a href="#">Habilitation services</a>	60% <a href="#">coinsurance</a>	70% <a href="#">coinsurance</a>	40 visit limit/year each for physical, occupational, and speech therapy. If an <a href="#">out-of-network provider</a> charges more than the <a href="#">allowed amount</a> , you may have to pay the difference ( <a href="#">balance billing</a> ).
	<a href="#">Skilled nursing care</a>	60% <a href="#">coinsurance</a>	70% <a href="#">coinsurance</a>	If an <a href="#">out-of-network provider</a> charges more than the <a href="#">allowed amount</a> , you may have to pay the difference ( <a href="#">balance billing</a> ).
	<a href="#">Durable medical equipment</a>	60% <a href="#">coinsurance</a>	70% <a href="#">coinsurance</a>	See policy documents. If an <a href="#">out-of-network provider</a> charges more than the <a href="#">allowed amount</a> , you may have to pay the difference ( <a href="#">balance billing</a> ).
	<a href="#">Hospice services</a>	60% <a href="#">coinsurance</a>	70% <a href="#">coinsurance</a>	If an <a href="#">out-of-network provider</a> charges more than the <a href="#">allowed amount</a> , you may have to pay the difference ( <a href="#">balance billing</a> ).
<b>If your child needs dental care 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 under age 19, per Calendar Year.
	Children's glasses	No Charge	25% <a href="#">coinsurance</a>	Coverage is limited to one frame per Covered Dependent Child under age 19, per Calendar Year.

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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)
- Dental Care (Child)
- Hearing Aids
- Long term care
- Non-emergency care when traveling outside the United States. See [www.mountainhealth.coop/plan-documents-wy](http://www.mountainhealth.coop/plan-documents-wy)
- Private-duty nursing unless the hospital does not an urgent or acute care unit.
- Religious counseling
- Reversal of an elective sterilization
- Roling therapy
- Self-help programs
- Temporomandibular joint dysfunction

### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- Acupuncture (Up to 12 visits/year)
- Bariatric surgery: Prior authorization required
- Chiropractic care (Up to 20 visits/year)
- Cosmetic surgery (Only if [medically necessary](#) or for certain reconstructive surgeries)
- Dental Care (Adult) up to \$100.00 limit
- Infertility treatment, except artificial fertilization
- Routine eye care (Adult) up to \$60.00 limit
- Routine foot care provided to a member with Diabetes
- Weight loss programs: Prior authorization required

**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 1-844-262-1560, State insurance department contact information at 1-866-444-3272 or <https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa>. State consumer assistance program at <http://www.cms.gov/cclIO/Resources/Consumer-Assistance-Grants>, Office of Personnel Management Multi State Plan Program at <https://www.opm.gov/healthcare-insurance/multi-state-plan-program/external-review/>. 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 1-844-262-1560.

### 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](#).

*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section*

\* For more information about limitations and exceptions, see the [plan](#) or policy document at <https://www.mountainhealth.coop/individual-plan-documents-wy>

## 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](#) \$7,200
- [Specialist](#) coinsurance 70%
- Hospital (facility) [coinsurance](#) 60%
- Other [coinsurance](#) 60%

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>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$7,200
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$1,000
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$8,260</b>

### Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$7,200
- [Specialist](#) coinsurance 70%
- Hospital (facility) [coinsurance](#) 60%
- Other [coinsurance](#) 60%

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>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$1,200
<a href="#">Copayments</a>	\$2,200
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>#3,420</b>

### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$7,200
- [Specialist](#) coinsurance 70%
- Hospital (facility) [coinsurance](#) 60%
- Other [coinsurance](#) 60%

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>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$2,800
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,800</b>

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