**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?** | Network provider: $1,000/ individual or $2,000/ family Out-of-network provider: $2,250/ individual or $4,500/ family | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. |
| **Are there services covered before you meet your deductible?** | Yes. Preventive care and primary care services are covered before you meet your deductible. | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/. |
| **Are there other deductibles for specific services?** | No | You don't have to meet deductibles for specific services. |
| **What is the out-of-pocket limit for this plan?** | Network provider: $6,500/ individual or $13,000/ family Out-of-network provider: $18,000/ individual or $36,000 / family | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| **What is not included in the out-of-pocket limit?** | Copayments for certain services, premiums, balance-billing charges, and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the out-of-pocket limit. |
| **Will you pay less if you use a network provider?** | Yes. See www.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 |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | $30 copayment/visit, deductible does not apply | 50% coinsurance | None |
| | Specialist visit | $50 copayment/visit, deductible does not apply | 50% coinsurance | None |
| | Preventive care/screening/ immunization | No charge | 50% coinsurance | 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) | 40% coinsurance | 50% coinsurance | Preauthorization may be required. See Section 6 of policy document for more information. |
| | Imaging (CT/PET scans, MRIs) | 40% coinsurance | 50% coinsurance | |
| **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: $5 copayment/prescription, deductible does not apply,<br><br>Mail Order: $10 copayment/prescription, deductible does not apply, | 50% coinsurance | Covers up to a 30-day supply (retail subscription); 30-90 day supply (mail order prescription). |
| | Preferred brand drugs | Retail: $40 copayment/prescription, deductible does not apply | 50% coinsurance | 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 |

| 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) | |
| | | Mail Order: $80 copayment/prescription, deductible does not apply, | | responsibility. |
| | Non-preferred brand drugs | Retail: $100 copayment/prescription, deductible does not apply<br><br>Mail Order: $200 copayment/prescription, deductible does not apply | 50% coinsurance | |
| | Specialty drugs | $150 copayment/prescription, deductible does not apply | 50% coinsurance | 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) | 30% coinsurance | 50% coinsurance | Preauthorization may be required. See Section 6 of policy document for more information. |
| | Physician/surgeon fees | 30% coinsurance | 50% coinsurance | |
| **If you need immediate medical attention** | Emergency room care | 40% coinsurance | 40% coinsurance | None |
| | Emergency medical transportation | 40% coinsurance | 40% coinsurance | |
| | Urgent care | $75 copayment/visit, deductible does not apply | 50% coinsurance | |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 40% coinsurance | 50% coinsurance | Preauthorization may be required. See Section 6 of policy document for more information. |
| | Physician/surgeon fees | 40% coinsurance | 50% coinsurance | |
| **If you need mental health, behavioral** | Outpatient services | First visit $0 then $30 copayment/visit, | 50% coinsurance | Preauthorization may be required. See Section 6 of policy document for more |

| 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) | |
| **health, or substance abuse services** | | deductible does not apply<br>Other: 40% coinsurance | | information. |
| | Inpatient services | 40% coinsurance | 50% coinsurance | |
| **If you are pregnant** | Office visits | $30 copayment/visit, deductible does not apply | 50% coinsurance | 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 Section 6 of policy document for more information. |
| | Childbirth/delivery professional services | 30% coinsurance | 50% coinsurance | |
| | Childbirth/delivery facility services | 30% coinsurance | 50% coinsurance | |
| **If you need help recovering or have other special health needs** | Home health care | 30% coinsurance | 50% coinsurance | Preauthorization may be required. See Section 6 of policy document for more information. |
| | Rehabilitation services | Office $75<br>Other: 30% coinsurance | 50% coinsurance | 40 visits/year for each physical, occupational, and speech therapy. Preauthorization may be required. See Section 6 of policy document for more information. |
| | Habilitation services | Office $75<br>Other: 30% coinsurance | 50% coinsurance | 40 visits/year for each physical, occupational, and speech therapy. Preauthorization may be required. See Section 6 of policy document for more information. |
| | Skilled nursing care | 30% coinsurance | 50% coinsurance | Preauthorization may be required. See Section 6 of policy document for more information. |
| | Durable medical equipment | 30% coinsurance | 50% coinsurance | |
| | Hospice services | 30% coinsurance | 50% coinsurance | |
| **If your child needs dental or eye care** | Children's eye exam | No Charge | 25% coinsurance | Coverage is limited to one exam/year for those under age 19. |
| | Children's glasses | No Charge | 25% coinsurance | Coverage is limited to one pair of eyeglasses/year for those under age 19. |

* For more information about limitations and exceptions, see the plan or policy document at www.mountainhealth.coop/plan-listing.

| 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) | |
| | 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.)**

- Abortion - except in the case of rape, incest, or when the life of the mother is in danger
- Dental Care (Child)
- Hearing Aids
- Long Term Care

**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 - Up to 1 per lifetime, preauthorization required
- Chiropractic Care - Up to 20 visits/year
- Cosmetic surgery - Only if medically necessary for certain reconstructive surgeries
- Dental Care (Adult) - up to $100 limit
- Infertility treatment, except artificial fertilization
- Non-emergency care when traveling outside the United States. See www.mountainhealth.coop/plan-listing for more information.
- Private-duty nursing – limited to inpatient hospitals without an ICU
- Routine eye care (Adult) - up to $60 limit
- Routine foot care provided to a member with Diabetes
- Weight loss programs - Preauthorization 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: For group health coverage subject to ERISA contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa.healthreform. For non-federal governmental group health plans contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323 x 61565 or www.cciio.cms.gov . Church plans are not covered by the Federal COBRA continuation rules. If the coverage is insurance individuals should contact their State Insurance Department regarding their possible rights to continue coverage. 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.

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**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: Wyoming Insurance Department at http://doi.wy.gov/consumers or 307-777-7402. You may also contact the Department of Labor's Employee Benefit Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.

**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/plan-listing.

**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.*

## 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** | **$1,000** |
| **Specialist coinsurance** | **$50** |
| **Hospital (facility) coinsurance** | **30%** |
| **Other coinsurance** | **30%** |

**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 | $1,000.00 |
| Copayments | $10.00 |
| Coinsurance | $3,000.00 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$4,070.00** |

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

| | |
|---|---|
| **The plan's overall deductible** | **$1,000** |
| **Specialist coinsurance** | **$50** |
| **Hospital (facility) coinsurance** | **30%** |
| **Other coinsurance** | **30%** |

**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 | $1,000.00 |
| Copayments | $1,000.00 |
| Coinsurance | $0.00 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$2,020.00** |

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

| | |
|---|---|
| **The plan's overall deductible** | **$1,000** |
| **Specialist coinsurance** | **$50** |
| **Hospital (facility) coinsurance** | **30%** |
| **Other coinsurance** | **30%** |

**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 | $1,000.00 |
| Copayments | $200.00 |
| Coinsurance | $500.00 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,700.00** |

The plan would be responsible for the other costs of these EXAMPLE covered services.