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/ 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.
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 doesn't have an out of pocket limit on your expenses.
Will you pay less if you use a network provider?	Yes. See **www.mountainhealth.coop** or call **1-855 447-2900** for information regarding network providers.	This plan uses a provider network. If you choose not to use a provider in the plan's network. 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.

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-Indian Health Care Provider (IHCP) (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	If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance billing). If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance billing). 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.
	Specialist visit	No Charge	No Charge	
	Preventive care/screening/ immunization	No Charge	No Charge	
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	No Charge	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)	No Charge	No Charge	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at plans/drug-list https://www.mountainhealth.coop/pharmacy	Generic drugs	No Charge	No Charge	31-day supply retail 90-day supply mail-order. 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 deductible and/or coinsurance, as applicable. 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 deductible and/or coinsurance, as applicable.
	Preferred brand drugs	No Charge	No Charge	
	Non-preferred brand drugs	No Charge	No Charge	
	Specialty drugs	No Charge	No Charge	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)	No Charge	No Charge	If an out-of-network provider charges more than the allowed amount, you may have to

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-Indian Health Care Provider (IHCP) (You will pay the most)	
	Physician/surgeon fees	No Charge	No Charge	pay the difference (balance billing).
If you need immediate medical attention	Emergency room care	No Charge	No Charge	If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance billing).
	Emergency medical transportation	No Charge	No Charge	
	Urgent care	No Charge	No Charge	
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	No Charge	If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance billing).
	Physician/surgeon fees	No Charge	No Charge	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No Charge	No Charge	If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance billing).
	Inpatient services	No Charge	No Charge	
If you are pregnant	Office visits	No Charge	No Charge	Included in delivery If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance billing). 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).
	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	If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance billing).
	Rehabilitation services	No Charge	No Charge	40 visit limit/year each for physical, occupational, and speech therapy. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance billing).
	Habilitation services	No Charge	No Charge	40 visit limit/year each for physical, occupational, and speech therapy. If an out-of-network provider charges more than the

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-Indian Health Care Provider (IHCP) (You will pay the most)	
				allowed amount, you may have to pay the difference (balance billing).
	Skilled nursing care	No Charge	No Charge	If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance billing).
	Durable medical equipment	No Charge	No Charge	See policy documents. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance billing).
	Hospice services	No Charge	No Charge	If an out-of-network provider charges more than the allowed amount, you may have to pay the difference (balance billing).
If your child needs dental or eye care	Children's eye exam	No Charge	No Charge	Coverage is limited to one Vision Examination per Covered Dependent Child under age 19, per Calendar Year.
	Children's glasses	No Charge	No Charge	Coverage is limited to one frame per Covered Dependent Child under age 19, per Calendar Year.

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/native-american-plan-documents-wy
- Private-duty nursing unless the hospital does not an urgent or acute care unit.
- Religious counseling
- Reversal of an elective sterilization
- Rolfing 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/ccIIO/Resources/Consmer-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 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.mountianhealth.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

*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	**$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	$60
The total Peg would pay is	$60

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	$20
The total Joe would pay is	$20

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.