

## Missoula Motor Parts

Access Care \$4000

<b>Benefit Plan Year</b>	November 1, 2023 – October 31, 2024	
<b>Benefit Accrual Period</b>	Plan Year	
<b>Maximum Lifetime Benefit</b>	<b>In-network</b>	<b>Out-of-network</b>
<b>Individual</b> (per member)	Unlimited	Unlimited
<b>Deductible</b>	<b>In-network</b>	<b>Out-of-network</b>
<b>Individual</b> (per member)	\$4,000	\$9,000
<b>Family</b> (per family)	\$8,000	\$18,000
<b>Out-of-Pocket Limit Per</b>	<b>In-network</b>	<b>Out-of-network</b>
<b>Individual</b> (per member)	\$8,550	\$24,450
<b>Family</b> (per family)	\$17,100	\$48,900
<b>Coinsurance</b>	<b>In-network</b>	<b>Out-of-network</b>
	40%	60%

This Policy provides a network through which members can receive benefits for allowable services from in-network providers. When using an in-network provider for covered medical expenses, the member is only responsible for applicable deductible, coinsurance and/or copayments of the allowable amount up to the maximum out-of-pocket. When using an out-of-network provider, the member is responsible for payment of billed charges beyond the allowed amount for covered medical expenses. Please note: The member is responsible for full charge of any non-covered medical expense. When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing. For more information about “surprise billing”, visit <https://mountainhealth.coop/members/> and review the information provided under “Surprise Billing”.

### COVERED BENEFITS

This Policy will pay Covered Medical Expenses incurred for Covered Benefits provided in Section 5 of your policy Document, Covered Benefits: based on the Allowable Fee, Deductible, Coinsurance, and Annual Out-of-Pocket Maximum amounts shown under the Benefit Information section of this Outline of Coverage. If a Copayment applies to a Covered Benefit, it will be indicated below in this Covered Benefits section. For Information regarding Prior Authorization requirements, please see section 6, Utilization Review, Management Program of your policy document.

Covered Benefit	YOUR COST IN-NETWORK	YOUR COST OUT-OF-NETWORK
Preventive Care		
Preventive/Wellness	No Charge	60% After Deductible

#### Professional Services\*

Primary care office visit – Tier 1 Provider	N/A	N/A
Primary care office visit – Tier 2 Provider	\$35 Copayment	60% After Deductible
Specialist office visit	\$75 Copayment	60% After Deductible
Therapy office visit - PT, OT, ST	\$75 Copayment	60% After Deductible
Doctor on Demand	\$0	N/A
Surgeon	40% After Deductible	60% After Deductible
Anesthesiologist	40% After Deductible	60% After Deductible
Outpatient habilitation services	40% After Deductible	60% After Deductible
Outpatient rehabilitation services	40% After Deductible	60% After Deductible
Chiropractic Services (20 visits per year)	\$75 Copayment	60% After Deductible

#### Hospital/Facility Services\*

Inpatient room and board	40% After Deductible	60% After Deductible
Inpatient habilitation services	40% After Deductible	60% After Deductible
Inpatient rehabilitation services	40% After Deductible	60% After Deductible
Skilled nursing facility care (60 days per year)	40% After Deductible	60% After Deductible
Outpatient surgery/services	40% After Deductible	60% After Deductible
Diagnostic and therapeutic radiology/laboratory and dialysis	40% After Deductible	60% After Deductible
Center of Excellence with prior approval by the Co-op	40% After Deductible	60% After Deductible
Urgent and Emergency Services		
Urgent care center	\$110 Copayment	60% After Deductible
Doctor on Demand	\$0	N/A

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<b>Emergency room</b>	50% After Deductible	50% After Deductible
<b>Ambulance; ground and air</b>	50% After Deductible	50% After Deductible
<b>Prescription Drug Benefit*</b>	<i>If you choose a higher Tier drug when a lower Tier drug is available, you may be subject to additional member responsibility.</i>	
<b>\$0 Out of Pocket Prescriptions</b> (Tier 5 online search)	No Charge	N/A
<b>Retail Pharmacy Prescriptions - (30-day supply)</b>		
Tier 1-Preferred Generic Drug	\$10 Copayment	60% After Deductible
Tier 2-Preferred Brand and Non-Preferred Generic Drugs	\$50 Copayment	60% After Deductible
Tier 3-Non-Preferred Brand Drugs	\$100 Copayment	60% After Deductible
Tier 4-Non-Preferred Brand Drugs (Specialty Drugs)	\$150 Copayment	N/A
<b>Mail Order Maintenance - (90-day supply)</b>		
Tier 1-Preferred Generic Drug	\$20 Copayment	N/A
Tier 2-Preferred Brand and Non-Preferred Generic Drugs	\$100 Copayment	N/A
Tier 3-Non-Preferred Brand Drugs	\$200 Copayment	N/A
<b>Mental Health, Autism Spectrum Disorder and Substance Use Disorder Services*</b>		
<b>Office visits</b>	\$35 Copayment	60% After Deductible
<b>Inpatient care</b>	40% After Deductible	60% After Deductible
<b>Outpatient care</b>	40% After Deductible	60% After Deductible
<b>Doctor on Demand</b>	\$0	N/A
<b>Residential programs</b>	40% After Deductible	60% After Deductible
<b>Other Covered Services*</b>		
<b>Durable medical equipment</b>	40% After Deductible	60% After Deductible
<b>Home health</b> (180 visits per year)	40% After Deductible	60% After Deductible
<b>Prosthetics</b>	40% After Deductible	60% After Deductible
<b>Transplants</b>	40% After Deductible	60% After Deductible
<b>Pediatric Vision Care Services</b>	<i>This Vision Care Benefit only applies to Covered Dependents under age 19.</i>	
<b>Vision examination</b> (One per year)	No Charge	25% After Deductible

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<b>Vision care materials</b> <i>(See policy for limitations)</i>	No Charge	25% After Deductible
<b>Vision Exam Reimbursement</b>	Reimbursement Maximum	
<b>Vision examination</b> <i>(One per year)</i>	\$60	
<b>Dental Exam Reimbursement</b>	Reimbursement Maximum	
<b>Dental exam/cleaning</b> <i>(One per year)</i>	\$100	

\*Prior authorization may be required.

**This is a brief summary of benefits. Refer to your policy for additional information or a further explanation of benefits, limitations, and exclusions.**

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