MOUNTAIN HEALTH CO-OP

Outline of Coverage

Edwards Jet Center and Law Firm CC $1000

Benefit Plan Year	October 1, 2023 – September 30, 2024	
Benefit Accrual Period	Calendar Year	
Maximum Lifetime Benefit	In-network	Out-of-network
Individual (per member)	Unlimited	Unlimited
Deductible	In-network	Out-of-network
Individual (per member) **Family** (per family)	$1,000 $2,000	$2,000 $4,000
Out-of-Pocket Limit Per	In-network	Out-of-network
Individual (per member) **Family** (per family)	$2,000 $4,000	$4,000 $8,000
Coinsurance	In-network	Out-of-network
	40%	50%

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.

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Covered Benefit	YOUR COST IN-NETWORK	YOUR COST OUT-OF-NETWORK
Preventive Care		
Preventive/Wellness	No Charge	50% After Deductible

Professional Services*		
Primary care office visit – Tier 1 Provider	N/A	N/A
Primary care office visit – Tier 2 Provider	$35 Copay	50% After Deductible
Specialist office visit	40% After Deductible	50% After Deductible
Therapy office visit - PT, OT, ST	40% After Deductible	50% After Deductible
Doctor on Demand	$0 Copay	N/A
Surgeon	40% After Deductible	50% After Deductible
Anesthesiologist	40% After Deductible	50% After Deductible
Outpatient habilitation services	40% After Deductible	50% After Deductible
Outpatient rehabilitation services	40% After Deductible	50% After Deductible
Chiropractic Services *(20 visits per year)*	40% Before Deductible	50% After Deductible
Hospital/Facility Services*		
Inpatient room and board	40% After Deductible	50% After Deductible
Inpatient habilitation services	40% After Deductible	50% After Deductible
Inpatient rehabilitation services	40% After Deductible	50% After Deductible
Skilled nursing facility care *(60 days per year)*	40% After Deductible	50% After Deductible
Outpatient surgery/services	40% After Deductible	50% After Deductible
Diagnostic and therapeutic radiology/laboratory and dialysis	40% After Deductible	50% After Deductible
Center of Excellence with prior approval by the Co-op	40% After Deductible	50% After Deductible
Urgent and Emergency Services		
Urgent care center	$35 Copay	50% After Deductible
Doctor on Demand	$0 Copay	N/A

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Emergency room	$100 Copay	$100 Copayment
Ambulance; ground and air	40% After Deductible	40% After Deductible
Prescription Drug Benefit*	*If you choose a higher Tier drug when a lower Tier drug is available, you may be subject to additional member responsibility.*	
$0 Out of Pocket Prescriptions (Tier 5 online search)	No Charge	50% After Deductible
Retail Pharmacy Prescriptions - (30-day supply)		
Tier 1-Preferred Generic Drug	$10 Copay	$15 Copay
Tier 2-Preferred Brand and Non-Preferred Generic Drugs	$40 Copay	$50 Copay
Tier 3-Non-Preferred Brand Drugs	60% up to $200 Maximum	60% up to $250 Maximum
Tier 4-Non-Preferred Brand Drugs (Specialty Drugs)	$100 Copay	N/A
Mail Order Maintenance - (90-day supply)		
Tier 1-Preferred Generic Drug	$20 Copay	N/A
Tier 2-Preferred Brand and Non-Preferred Generic Drugs	$80 Copay	N/A
Tier 3-Non-Preferred Brand Drugs	60% up to $400 Maximum	N/A
Mental Health, Autism Spectrum Disorder and Substance Use Disorder Services*		
Office visits	$35 Copay	50% After Deductible
Inpatient care	40% After Deductible	50% After Deductible
Outpatient care	40% After Deductible	50% After Deductible
Doctor on Demand	$0 Copay	N/A
Residential programs	40% After Deductible	50% After Deductible
Other Covered Services*		
Durable medical equipment	40% After Deductible	50% After Deductible
Home health *(180 visits per year)*	40% After Deductible	50% After Deductible
Prosthetics	40% After Deductible	50% After Deductible
Transplants	40% After Deductible	50% After Deductible
Pediatric Vision Care Services	*This Vision Care Benefit only applies to Covered Dependents under age 19.*	
Vision examination *(One per year)*	No Charge	25% After Deductible

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Vision care materials *(See policy for limitations)*	No Charge	25% After Deductible
Vision Exam Reimbursement	Reimbursement Maximum	
Vison examination *(One per year)*	$60	
Dental Exam Reimbursement	Reimbursement Maximum	
Dental exam/cleaning *(One per year)*	$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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