



# Outline of Coverage

## Greater Valley Health Center

CC HDHP \$4500

<b>Benefit Plan Year</b>	July 1, 2023 – June 30, 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)	\$4,500	\$9,000
<b>Family</b> (per family)	\$9,000	\$18,000
<b>Out-of-Pocket Limit Per</b>	<b>In-network</b>	<b>Out-of-network</b>
<b>Individual</b> (per member)	\$4,500	\$9,000
<b>Family</b> (per family)	\$9,000	\$18,000
<b>Coinsurance</b>	<b>In-network</b>	<b>Out-of-network</b>
	0%	0%

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	0% After Deductible

#### Professional Services\*

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

#### Hospital/Facility Services\*

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

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<b>Emergency room</b>	0% After Deductible	0% After Deductible
<b>Ambulance; ground and air</b>	0% After Deductible	0% 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	0% After Deductible	0% After Deductible
Tier 2-Preferred Brand and Non-Preferred Generic Drugs	0% After Deductible	0% After Deductible
Tier 3-Non-Preferred Brand Drugs	0% After Deductible	0% After Deductible
Tier 4-Non-Preferred Brand Drugs (Specialty Drugs)	0% After Deductible	N/A
<b>Mail Order Maintenance - (90-day supply)</b>		
Tier 1-Preferred Generic Drug	0% After Deductible	N/A
Tier 2-Preferred Brand and Non-Preferred Generic Drugs	0% After Deductible	N/A
Tier 3-Non-Preferred Brand Drugs	0% After Deductible	N/A
<b>Mental Health, Autism Spectrum Disorder and Substance Use Disorder Services*</b>		
<b>Office visits</b>	0% After Deductible	0% After Deductible
<b>Inpatient care</b>	0% After Deductible	0% After Deductible
<b>Outpatient care</b>	0% After Deductible	0% After Deductible
<b>Doctor on Demand</b>	0% After Deductible	N/A
<b>Residential programs</b>	0% After Deductible	0% After Deductible
<b>Other Covered Services*</b>		
<b>Durable medical equipment</b>	0% After Deductible	0% After Deductible
<b>Home health</b> (180 visits per year)	0% After Deductible	0% After Deductible
<b>Prosthetics</b>	0% After Deductible	0% After Deductible
<b>Transplants</b>	0% After Deductible	0% 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	0% After Deductible

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<b>Vision care materials</b> <i>(See policy for limitations)</i>	No Charge	0% 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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