



Outline of Coverage

CBI Offroad Fab, LLC

Engage \$1500

| | | |
|---------------------------------|-------------------------|-----------------------|
| Benefit Plan Year | January 1 – December 31 | |
| 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) | \$1,500 | \$3,000 |
| Family (per family) | \$3,000 | \$6,000 |
| Out-of-Pocket Limit Per | In-network | Out-of-network |
| Individual (per member) | \$1,500 | \$3,000 |
| Family (per family) | \$3,000 | \$6,000 |
| Coinsurance | In-network | Out-of-network |
| | 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 | 0% After Deductible | 0% After Deductible |
| Specialist office visit | 0% After Deductible | 0% After Deductible |
| Therapy office visit - PT, OT, ST <i>(20 visits per year combined)</i> | 0% After Deductible | 0% After Deductible |
| Doctor on Demand | 0% After Deductible | Not Applicable |
| Surgeon | 0% After Deductible | 0% After Deductible |
| Anesthesiologist | 0% After Deductible | 0% After Deductible |
| Outpatient habilitation services <i>(20 visits per year combined)</i> | 0% After Deductible | 0% After Deductible |
| Outpatient rehabilitation services <i>(20 visits per year combined)</i> | 0% After Deductible | 0% After Deductible |
| Chiropractic Services <i>(20 visits per year)</i> | 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 <i>(30 days per year)</i> | 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 |

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| Doctor on Demand | 0% After Deductible | N/A |
| Emergency room | 0% After Deductible | 0% After Deductible |
| Ambulance; ground and air | 0% After Deductible | 0% After Deductible |
| Prescription Drug Benefit* | <i>If you choose a higher Tier drug when a lower Tier drug is available, you may be subject to additional member responsibility.</i> | |
| \$0 Out of Pocket Prescriptions (Tier 5 online search) | No Charge | N/A |
| Retail Pharmacy Prescriptions - (30-day supply) | | |
| 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 | 0% After Deductible |
| Mail Order Maintenance - (90-day supply) | | |
| 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 |
| Mental Health, Autism Spectrum Disorder and Substance Use Disorder Services* | | |
| Office visits | 0% After Deductible | 0% After Deductible |
| Inpatient care | 0% After Deductible | 0% After Deductible |
| Outpatient care | 0% After Deductible | 0% After Deductible |
| Doctor on Demand | 0% After Deductible | N/A |
| Residential programs | 0% After Deductible | 0% After Deductible |
| Other Covered Services* | | |
| Durable medical equipment | 0% After Deductible | 0% After Deductible |
| Home health | 0% After Deductible | 0% After Deductible |
| Prosthetics | 0% After Deductible | 0% After Deductible |
| Transplants | 0% After Deductible | 0% After Deductible |
| Hearing Device (For dependents under age 19) | No Charge | No Charge |
| | | |

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| Pediatric Vision Care Services | | <i>This Vision Care Benefit only applies to Covered Dependents under age 19.</i> |
| Vision examination <i>(One per year)</i> | No Charge | 0% After Deductible |
| Vision care materials <i>(See policy for limitations)</i> | No Charge | 0% After Deductible |
| Vision Exam Reimbursement | | Reimbursement Maximum |
| Vision examination <i>(One per year)</i> | | \$60 |
| Dental Exam Reimbursement | | Reimbursement Maximum |
| Dental exam/cleaning <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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