MOUNTAIN HEALTH CO-OP

Outline of Coverage

Fremont School District

Engage $350

Benefit Plan Year	September 1, 2023 – August 31, 2023	
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)	$350 $700	$700 $1,400
Out-of-Pocket Limit Per	In-network	Out-of-network
Individual (per member) **Family** (per family)	$3,250 $6,500	$ 6,500 $13,000
Coinsurance	In-network	Out-of-network
	15%	30%

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	30% After Deductible

Professional Services*		
Primary care office visit	$20 Copay	30% After Deductible
Specialist office visit	$30 Copay	30% After Deductible
Therapy office visit - PT, OT, ST *(20 visits per year combined)*	15% After Deductible	30% After Deductible
Doctor on Demand	$0 Copay	Not Applicable
Surgeon	15% After Deductible	30% After Deductible
Anesthesiologist	15% After Deductible	30% After Deductible
Outpatient habilitation services *(20 visits per year combined)*	15% After Deductible	30% After Deductible
Outpatient rehabilitation services *(20 visits per year combined)*	15% After Deductible	30% After Deductible
Chiropractic Services *(10 visits per year)*	15% After Deductible	30% After Deductible
Hospital/Facility Services*		
Inpatient room and board	15% After Deductible	30% After Deductible
Inpatient habilitation services	15% After Deductible	30% After Deductible
Inpatient rehabilitation services	15% After Deductible	30% After Deductible
Skilled nursing facility care *(30 days per year)*	15% After Deductible	30% After Deductible
Outpatient surgery/services	15% After Deductible	30% After Deductible
Diagnostic and therapeutic radiology/laboratory and dialysis	15% After Deductible	30% After Deductible
Center of Excellence with prior approval by the Co-op	15% After Deductible	30% After Deductible
Urgent and Emergency Services		
Urgent care center	15% After Deductible	30% After Deductible
Doctor on Demand	$0 Copay	N/A

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Emergency room	$100 Copayment	$100 Copayment
Ambulance; ground and air	15% After Deductible	30% 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	N/A
Retail Pharmacy Prescriptions - (30-day supply)		
Tier 1-Preferred Generic Drug	$10 Copay	30% After Deductible
Tier 2-Preferred Brand and Non-Preferred Generic Drugs	$30 Copay	30% After Deductible
Tier 3-Non-Preferred Brand Drugs	$60 Copay	30% After Deductible
Tier 4-Non-Preferred Brand Drugs (Specialty Drugs)	$100 Copay	30% After Deductible
Mail Order Maintenance - (90-day supply)		
Tier 1-Preferred Generic Drug	$20 Copay	N/A
Tier 2-Preferred Brand and Non-Preferred Generic Drugs	$60 Copay	N/A
Tier 3-Non-Preferred Brand Drugs	$120 Copay	N/A
Mental Health, Autism Spectrum Disorder and Substance Use Disorder Services*		
Office visits	$20 Copay	% After Deductible
Inpatient care	15% After Deductible	30% After Deductible
Outpatient care	15% After Deductible	30% After Deductible
Doctor on Demand	$0 Copay	Not Applicable
Residential programs	15% After Deductible	30% After Deductible
Other Covered Services*		
Durable medical equipment	15% After Deductible	30% After Deductible
Home health	15% After Deductible	30% After Deductible
Prosthetics	15% After Deductible	30% After Deductible
Transplants	15% After Deductible	30% After Deductible
Hearing Device *(For dependents under age 19)*	No Charge	No Charge
Pediatric Vision Care Services	*This Vision Care Benefit only applies to Covered*	

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Dependents under age 19.		
Vision examination *(One per year)*	No Charge	25% After Deductible
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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