MOUNTAIN HEALTH CO-OP

# Outline of Coverage

## Sheridan Motors — High Plains $2500

| | | |
|---|---|---|
| **Benefit Plan Year** | January 1, 2024 – December 31, 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)<br>**Family** (per family) | $2,500<br>$5,000 | $5,000<br>$10,000 |
| Out-of-Pocket Limit Per | In-network | Out-of-network |
| **Individual** (per member)<br>**Family** (per family) | $2,500<br>$5,000 | $5,000<br>$10,000 |
| 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.

| 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** *(40 visits per year for physical therapy and combined 20 visits per calendar year maximum for occupational and speech therapy)* | 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** | 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 |

| | | |
|---|---|---|
| **Emergency room** | 0% After Deductible | 0% After Deductible |
| **Ambulance; ground and air** | 0% After Deductible | 0% 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 | $15 Copay | 0% After Deductible |
| Tier 2-Preferred Brand and Non-Preferred Generic Drugs | $45 Copay | 0% After Deductible |
| Tier 3-Non-Preferred Brand Drugs | $60 Copay | 0% After Deductible |
| Tier 4-Non-Preferred Brand Drugs (Specialty Drugs) | 0% After Deductible | N/A |
| **Mail Order Maintenance -** (90-day supply) | | |
| Tier 1-Preferred Generic Drug | $30 Copay | N/A |
| Tier 2-Preferred Brand and Non-Preferred Generic Drugs | $90 Copay | N/A |
| Tier 3-Non-Preferred Brand Drugs | $180 Copay | 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 |
| **Bariatric Surgery** *(One surgery per lifetime)* | 0% After Deductible | 0% 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 | 0% After Deductible |

Mountain Health Co-op does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation, or health status in the administration of the plan, including enrollment and benefit determinations.

| | | |
|---|---|---|
| **Vision care materials**<br>*(See policy for limitations)* | No Charge | 0% After Deductible |
| Vision Exam Reimbursement | Reimbursement Maximum | |
| **Vison examination**<br>*(One per year)* | $60 | |
| Dental Exam Reimbursement | Reimbursement Maximum | |
| **Dental exam/cleaning**<br>*(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.**