MOUNTAIN HEALTH CO-OP

Outline of Coverage

Security State Bank — High Plains $3200

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) **Family** (per family)	$3,200 $6,400	$6,400 $12,800
Out-of-Pocket Limit Per	In-network	Out-of-network
Individual (per member) **Family** (per family)	$6,400 $12,800	$12,800 $25,600
Coinsurance	In-network	Out-of-network
	20%	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.

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	20% After Deductible	50% After Deductible
Specialist office visit	20% After Deductible	50% 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)*	20% After Deductible	50% After Deductible
Acupuncture *(12 visits per year)*	20% After Deductible	50% After Deductible
Doctor on Demand	20% After Deductible	N/A
Surgeon	20% After Deductible	50% After Deductible
Anesthesiologist	20% After Deductible	50% After Deductible
Outpatient rehabilitation services *(40 visits per year for physical therapy and combined 20 visits per calendar year maximum for occupational and speech therapy)*	20% After Deductible	50% After Deductible
Outpatient habilitation services *(40 visits per year for physical therapy and combined 20 visits per calendar year maximum for occupational and speech therapy)*	20% After Deductible	50% After Deductible
Chiropractic Services *(15 visits per year)*	20% After Deductible	50% After Deductible
Hospital/Facility Services*		
Inpatient room and board	20% After Deductible	50% After Deductible
Inpatient rehabilitation/habilitation services	20% After Deductible	50% After Deductible
Skilled nursing facility care	20% After Deductible	50% After Deductible
Outpatient surgery/services	20% After Deductible	50% After Deductible
Diagnostic and therapeutic radiology/laboratory and dialysis	20% After Deductible	50% After Deductible
Center of Excellence with prior approval by the Co-op	20% After Deductible	50% After Deductible

Urgent and Emergency Services		
Urgent care center	20% After Deductible	50% After Deductible
Doctor on Demand	20% After Deductible	N/A
Emergency room	20% After Deductible	20% After Deductible
Ambulance; ground and air	20% After Deductible	20% 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 (Value Preventive Drug List)	No Charge	N/A
Retail Pharmacy Prescriptions - (up to 30-day supply)		
Tier 1-Preferred Generic Drug	$10 Copay After Deductible	$20 Copay After Deductible
Tier 2-Preferred Brand and Non-Preferred Generic Drugs	$35 Copay After Deductible	$70 Copay After Deductible
Tier 3-Non-Preferred Brand Drugs	$60 Copay After Deductible	$120 Copay After Deductible
Tier 4-Specialty Drugs	$200 Copay After Deductible	N/A
Mail Order Maintenance - (up to 90-day supply)		
Tier 1-Preferred Generic Drug	$25 Copay After Deductible	N/A
Tier 2-Preferred Brand and Non-Preferred Generic Drugs	$87.50 Copay After Deductible	N/A
Tier 3-Non-Preferred Brand Drugs	$150 Copay After Deductible	N/A
Mental Health, Autism Spectrum Disorder and Substance Use Disorder Services*		
Office visits	20% After Deductible	50% After Deductible
Inpatient care	20% After Deductible	50% After Deductible
Outpatient care	20% After Deductible	50% After Deductible
Doctor on Demand	20% After Deductible	N/A
Residential programs	20% After Deductible	50% After Deductible
Other Covered Services*		
Durable medical equipment	20% After Deductible	50% After Deductible
Home health	20% After Deductible	50% After Deductible
Prosthetics	20% After Deductible	50% After Deductible
Transplants	20% After Deductible	50% After Deductible
Bariatric Surgery *(One surgery per lifetime)*	20% After Deductible	50% 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.

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
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.