

## Legacy Rehab Services, LLC

## Link Silver

<b>Benefit Plan Year</b>	December 1, 2023 – November 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)	\$5,000	\$10,000
<b>Family</b> (per family)	\$10,000	\$20,000
<b>Out-of-Pocket Limit Per</b>	<b>In-network</b>	<b>Out-of-network</b>
<b>Individual</b> (per member)	\$ 8,550	\$17,100
<b>Family</b> (per family)	\$17,100	\$34,200
<b>Coinsurance</b>	<b>In-network</b>	<b>Out-of-network</b>
	40%	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
<b>Preventive Care</b>		
<b>Preventive/Wellness</b>	No Charge	50% After Deductible

<b>Professional Services*</b>		
<b>Primary care office visit</b>	\$20 Copay	50% After Deductible
<b>Specialist office visit</b>	\$50 Copay	50% After Deductible
<b>Therapy office visit - PT, OT, ST</b> <i>(20 visits per year combined)</i>	\$50 Copay	50% After Deductible
<b>Doctor on Demand</b>	\$0 Copay	Not Applicable
<b>Surgeon</b>	40% After Deductible	50% After Deductible
<b>Anesthesiologist</b>	40% After Deductible	50% After Deductible
<b>Outpatient habilitation services</b> <i>(20 visits per year combined)</i>	40% After Deductible	50% After Deductible
<b>Outpatient rehabilitation services</b> <i>(20 visits per year combined)</i>	40% After Deductible	50% After Deductible
<b>Chiropractic Services</b> <i>(20 visits per year)</i>	\$50 Copay	50% After Deductible
<b>Hospital/Facility Services*</b>		
<b>Inpatient room and board</b>	40% After Deductible	50% After Deductible
<b>Inpatient habilitation services</b>	40% After Deductible	50% After Deductible
<b>Inpatient rehabilitation services</b>	40% After Deductible	50% After Deductible
<b>Skilled nursing facility care</b> <i>(30 days per year)</i>	40% After Deductible	50% After Deductible
<b>Outpatient surgery/services</b>	40% After Deductible	50% After Deductible
<b>Diagnostic and therapeutic radiology/laboratory and dialysis</b>	40% After Deductible	50% After Deductible
<b>Center of Excellence with prior approval by the Co-op</b>	40% After Deductible	50% After Deductible
<b>Urgent and Emergency Services</b>		
<b>Urgent care center</b>	\$75 Copay	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.

<b>Doctor on Demand</b>	\$0 Copay	N/A
<b>Emergency room</b>	50% After Deductible	50% After Deductible
<b>Ambulance; ground and air</b>	50% After Deductible	50% 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	\$10 Copay	50% After Deductible
Tier 2-Preferred Brand and Non-Preferred Generic Drugs	\$75 Copay	50% After Deductible
Tier 3-Non-Preferred Brand Drugs	35% After Deductible	50% After Deductible
Tier 4-Non-Preferred Brand Drugs (Specialty Drugs)	40% After Deductible	50% After Deductible
<b>Mail Order Maintenance - (90-day supply)</b>		
Tier 1-Preferred Generic Drug	\$20 Copay	N/A
Tier 2-Preferred Brand and Non-Preferred Generic Drugs	\$150 Copay	N/A
Tier 3-Non-Preferred Brand Drugs	35% After Deductible	N/A
<b>Mental Health, Autism Spectrum Disorder and Substance Use Disorder Services*</b>		
<b>Office visits</b>	\$20 Copay	50% After Deductible
<b>Inpatient care</b>	40% After Deductible	50% After Deductible
<b>Outpatient care</b>	40% After Deductible	50% After Deductible
<b>Doctor on Demand</b>	\$0 Copay	Not Applicable
<b>Residential programs</b>	40% After Deductible	50% After Deductible
<b>Other Covered Services*</b>		
<b>Durable medical equipment</b>	40% After Deductible	50% After Deductible
<b>Home health</b>	40% After Deductible	50% After Deductible
<b>Prosthetics</b>	40% After Deductible	50% After Deductible
<b>Transplants</b>	40% After Deductible	50% After Deductible
<b>Hearing Device</b> (For dependents under age 19)	No Charge	No Charge

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.

<b>Pediatric Vision Care Services</b>		<i>This Vision Care Benefit only applies to Covered Dependents under age 19.</i>
<b>Vision examination</b> <i>(One per year)</i>	No Charge	25% After Deductible
<b>Vision care materials</b> <i>(See policy for limitations)</i>	No Charge	25% After Deductible
<b>Vision Exam Reimbursement</b>		<b>Reimbursement Maximum</b>
<b>Vision examination</b> <i>(One per year)</i>		\$60
<b>Dental Exam Reimbursement</b>		<b>Reimbursement Maximum</b>
<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.**

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.