MOUNTAIN HEALTH CO-OP

Summary of Benefits

SW MT Community Health Center $500 Plus

Summary of Benefits			
Benefit Plan Year **Benefit Accrual Period**	July 1, 2022 – June 30, 2023 Plan Year		
Deductible *Copayments and coinsurance do not accumulate to deductible.	In-Network: Out-of-Network:	Individual $500 Individual $1,000	Family $1,000 Family $2,000
Annual Out-of-Pocket Maximum	In-Network: Out-of-Network:	Individual $2,000 Individual $4,000	Family $4,000 Family $8,000
Coinsurance	In-Network: 20%		Out-of-Network: 40%
Copayment	Copayments are in addition to deductible and coinsurance. Once the Out-of-Pocket Maximum is satisfied; deductible, coinsurance and copayments do not apply.		
Network	Plus Connected Care		

Deductible and coinsurance apply to all services as noted below. There is no lifetime maximum benefit limit for this plan. This is only a summary of benefits. Benefits and general provisions described herein are subject to the terms of the Member Guide and Group Contract. Prior Authorization is not a guarantee of payment but is recommended for some services, supplies, treatments, and prescription drugs to help the Member identify potential expenses, payment reductions, or claim denials that may occur if these proposed services are not Medically Necessary or not a Covered Medical Expense. Refer to your Member Guide.

The member is responsible for the above deductible and the following copays and coinsurance:

Services	In-Network:	Out-of-Network:
Preventive Care		
Preventive Health Care Services for health care screenings or preventive purposes submitted with a routine diagnosis will be covered at 100% of the Allowable Fee. This means that these Benefits are not subject to the Deductible, Coinsurance, Copayments, or Annual Out-of- Pocket Maximum when services are provided by an In-Network provider. However, if Preventive Health Care Services are rendered for an established medical condition or by an Out-of-Network Provider, the Preventive Health Care Services provided will be subject to the Out-of-Network Deductible, Coinsurance, Copayments, and Annual Out-of-Pocket Maximum.		40% after Deductible (Out of network-Well Child Care visits covered at 100% before deductible; Mammograms covered at a minimum payment of $70 before deductible)
Physician Medical Services		
Physician Office Visits (CHC) – Tier 1 Provider	$10 Copayment	40% after Deductible
Physician Office Visits (Non-Specialist) – Tier 2 Provider	$30 Copayment	40% after Deductible
Physician Specialist Visits	$30 Copayment	40% after Deductible
Doctor on Demand (Virtual Visits)	$20 Copayment	N/A
Hospital Services-Facility and Professional		
Inpatient Facility	20% after Deductible	40% after Deductible
Outpatient Facility	20% after Deductible	40% after Deductible
Emergency Services		
Emergency room visits	$100 Copayment	40% after Deductible

Services	In-Network:	Out-of-Network:
Ambulance (Air or Ground)	20% after Deductible	40% after Deductible
Urgent Care Visit	$50 Copayment	40% after Deductible
Prescription Drugs Benefit		
Retail Pharmacy Benefit (up to a 31-day supply)		
Preferred Generic Drugs (Tier 1)	$20 Copayment	40% after Deductible
Non-Preferred Generic & Preferred Brand Drugs (Tier 2)	$80 Copayment	40% after Deductible
Non-Preferred Brand Drugs (Tier 3)	$200 Copayment	40% after Deductible
Specialty Drugs (Tier 4)	$100 Copayment	N/A
Mail Order Pharmacy Benefit (up to a 90-day supply)		
Preferred Generic Drugs (Tier 1)	$40 Copayment	N/A
Non-Preferred Generic & Preferred Brand Drugs (Tier 2)	$160 Copayment	N/A
Non-Preferred Brand Drugs (Tier 3)	$400 Copayment	N/A
Specialty Drugs (Tier 4) (31-Day Supply Only)	N/A	N/A
Co-Op Value Preventive Drugs	No Charge	N/A
Generic medications required or you will pay the copay/coinsurance plus cost difference between brand and generic medication.		
Mental Health/Chemical Dependency Services		
Inpatient / other Outpatient Facility Services	20% after Deductible	40% after Deductible
Office Visit – Tier 1 Provider (CHC)	$10 Copayment	40% after Deductible
Office Visit – Tier 2 Provider	$30 Copayment	40% after Deductible
Other Covered Services *(This is not a complete list. Check your policy or plan document for other covered services and your costs for these services.)*		
Chiropractic Care-*Maximum Number of Office Visits per Calendar Year – 20 visits*	20% after Deductible	40% after Deductible
Convalescent Home Services-*Maximum Number of Days per Calendar Year – 60 days*	20% after Deductible	40% after Deductible
Dental Care Reimbursement	Balance After Dental Reimbursement	Balance After Dental Reimbursement
Durable Medical Equipment *Rental (up to the purchase price), Purchase and Repair and Replacement of Durable Medical Equipment.*	20% after Deductible	40% after Deductible
Home Health Care Services	20% after Deductible	40% after Deductible
Laboratory Services	20% after Deductible	40% after Deductible
Therapeutic Services (PT, OT, ST) *20 visit limit combined*	20% after Deductible	40% after Deductible
Transplant Services	20% after Deductible	40% after Deductible
Vision Care Reimbursement	Balance After Vision Reimbursement	Balance After Vision Reimbursement
Pediatric Vision Care Services (Applies to covered dependent children under age 19)		

Services	In-Network:	Out-of-Network:
Examination *One exam per covered dependent child per calendar year*	No Charge	25% after Deductible
Lenses Single Vision Bifocal Trifocal Lenticular *Coverage includes lenses in polycarbonate, plastic or glass, scratch resistant or UV coatings also covered. One set of lenses per covered dependent per calendar year*	No Charge	25% after Deductible
Frames *One frame per covered dependent child per calendar year. Frame selection will be from a pediatric exchange collection.*	No Charge	25% after Deductible
Contact Lenses Necessary Professional Fees and Materials Elective Professional Fees and Materials *15% discount applies to the Providers usual and customary professional fees for contract lens evaluation and fitting.*	No Charge In Lieu of Glasses	25% after Deductible In Lieu of Glasses

This is a brief summary of benefits. Refer to your complete policy document for additional information or a further explanation of benefits, limitations, and exclusions.

What is the annual deductible?

Your plan's deductible is the fixed dollar amount of Covered Medical Expenses that you must incur for certain Covered Benefits before MHC begins paying benefits for them. The Deductible must be satisfied each accrual period defined on the first page of this Outline of Coverage by each Covered Person, except as provided under *"Family Deductible Limit"* provision. Only the Allowable Fee for Covered Medical Expenses is applied to the Deductible. The following do not apply towards satisfaction of the Deductible: (1) services, treatments or supplies that are not covered under this Policy; and (2) amounts billed by Out-of-Network Providers, which include the Out-of-Network Provider Differential.

What is the annual out-of-pocket maximum?

The Annual Out-of-Pocket Maximum is the maximum amount that the Covered Person must pay every accrual period for Covered Medical Expenses incurred for Covered Benefits. The Annual Out-of-Pocket Maximum is shown in the Schedule of Benefits. It applies to all Covered Benefits except the *Preventive Health Care Services Benefit*.

The Annual Out-of-Pocket Maximum includes the following:

1. Calendar Year Deductible;
2. Copayments; and
3. Coinsurance.

When the Annual Out-of-Pocket Maximum is satisfied in the accrual period, We will then pay 100% of Covered Medical Expenses incurred for Covered Benefits for the remainder of that Calendar Year. The Annual Out-of-Pocket Maximum must be satisfied each Calendar Year.

The exception to this is in regards to out-of-network charges. The amount the plan pays for covered services is based on the allowed amount. **If an out-of-network provider charges more than the allowed amount, you may have to pay the difference**. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the allowed amount is $1,000, you may have to pay the $500 difference which does not apply to the deductible, coinsurance, or Out of Pocket Maximum. (This is called balance billing.)

Payments to providers

Payment to providers is based on the prevailing or contracted Mountain Health CO-OP fee allowance for covered services. Although In-Network Providers accept the fee allowance as payment in full, Out-of-Network Providers may not. Services of Out-of-Network Providers could result in out-of-pocket expense in addition to the percentage indicated.

Preauthorization

Coverage of certain medical services and surgical procedures requires a benefit determination by Mountain Health CO-OP before the services are performed. This process is called 'preauthorization'. Preauthorization is necessary to determine if certain services and supplies are covered under this plan, and if you meet the plan's eligibility requirements. You'll find the most current preauthorization list in your complete policy document.

The Patient's right to know the costs of medical procedures.

The insured, or the insured's agent, may request an estimate of the member's portion of provider charges for any service or course of treatment that exceeds $500. Mountain Health CO-OP shall make a good faith effort to provide accurate information based on cost estimates and procedure codes obtained by the insured from the insured's health care provider. The estimate may be provided in writing or electronically. It is not a binding contract between Mountain Health CO-OP and the member, and is not a guarantee that the estimated amount will be the charged amount, or that it will include charges for unforeseen conditions. Contact Customer Service at (855) 488-0622 to request an estimate.

Provider Networks

Organization (PPO) (In-Network) - An innovative health care partnership developed by MHC and our Preferred Hospital Providers to offer health care services to Members at lower premiums. This network is composed of hospitals or surgery centers across the state that accept lower payments for each hospital or surgery center service or inpatient stay.

Participating Providers accept the MHC allowable fee, in addition to the deductible, coinsurance and copayment, as payment in full for covered services. These providers will submit claims for you, and MHC will pay the participating provider directly. There is no billing to you over your deductible, coinsurance and copayment.

Nonparticipating Provider (Out-of-Network) - Nonparticipating Providers have not contracted with MHC to provide services at negotiated rates, and your out of pocket expenses can be significantly higher. Nonparticipating providers are under no obligation to submit claims for you. You may receive payment for claims received from a nonparticipating provider.

If a Primary Care Provider (PCP), Primary Care Provider Specialist (PCPS), Common Specialty Care Provider (CSCP) or a Less Common Sub-Specialty Care Provider (LCSP) is not located within 60 miles, the member can go outside of the 60 miles to a network Provider (an authorization may be required.) MHC will pay as participating and the member may be balanced billed. If the member sees a provider outside of that 60 miles and the provider is not in network the benefits will go towards the out-of-network deductible and out-of-pocket maximum.

Out-of-network emergency room services to treat an emergency medical condition are reimbursed as if obtained in-network, if an in-network emergency room cannot be reasonably reached. An emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition that places the health of the individual in serious jeopardy, would result in serious impairment to bodily functions, or serious dysfunction of any bodily organ or part; or with respect to a pregnant woman having contractions, that there is inadequate time to safely transfer the woman to another hospital for delivery or that a transfer may pose a threat to the health or safety of the woman or the fetus.

Finding Participating Providers– To locate Participating Providers and PPO hospitals and surgery centers in Mountain check our on-line provider directory at www.mhc.coop/provider-finder/ or contact Customer Service at 1-855-447-2900. Be sure to have your health plan identification number available when you call.