MOUNTAIN HEALTH CO-OP

Outline of Coverage

HIGH PLAINS INDIVIDUAL GOLD WYOMING NALC

Read Your Policy Carefully – This managed care Outline Of Coverage (OOC) provides a very brief description of important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations, of both you and those of Mountain Health Co-op. It is, therefore, important that you **please read your policy carefully**.

Provider Network: High Plains **Coverage Year**: 2023

Premium Due Date: 1st day of each month **Premium:** [ ]

Maximum Lifetime Benefit	In-network	Out-of-network
Individual (per member)	Unlimited	Unlimited
Deductible – Benefit/Plan Year	**In-network**	**Out-of-network**
Individual (per member)	$1,000	$3,000
Family (per family)	$2,000	$6,000
Out-of-Pocket Limit Per Benefit/Plan Year	**In-network**	**Out-of-network**
Individual (per member)	$6,000	$18,000
Family (per family)	$12,000	$36,000
Coinsurance	**In-network**	**Out-of-network**
	30%	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 section 6, *Utilization Review, Management Program*.

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Covered Benefit	Indian Health Care Provider (IHCP)	Your Cost In-Network	Your Cost Out-Of-Network
Preventive Care	Prior Authorization May be Required		
Preventive/Wellness	0% no deductible	0% no deductible	50% after deductible

Professional Services	Prior Authorization May be Required		
	Indian Health Care Provider (IHCP)	Your Cost In-Network	Your Cost Out-Of-Network
Primary care provider	0% no deductible	$35 no deductible	50% after deductible
Specialist office visit	0% no deductible	$50 no deductible	50% after deductible
Therapy office visit -PT, OT, ST – (40 visits per calendar year for physical therapy and combined 20 visit per calendar year maximum for occupational therapy & speech therapy.)	0% no deductible	$50 no deductible	50% after deductible
Acupuncture (12 visits per benefit/plan year)	0% no deductible	30% after deductible	50% after deductible
Doctor on Demand	NA	$20 no deductible	NA
Surgeon	0% no deductible	30% after deductible	50% after deductible
Anesthesiologist	0% no deductible	30% after deductible	50% after deductible
Outpatient habilitation services – (40 visits per calendar year for physical therapy and combined 20 visit per calendar year maximum for occupational therapy & speech therapy.)	0% no deductible	30% after deductible	50% after deductible
Outpatient rehabilitation services- (40 visits per calendar year for physical therapy and combined 20 visit per calendar year maximum for OT & ST)	0% no deductible	30% after deductible	50% after deductible
Hospital/Facility Services	Prior Authorization May be Required		

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	Indian Health Care Provider (IHCP)	Your Cost in Network	Your Cost Out-Of-Network
Inpatient room and board	0% no deductible	30% after deductible	50% after deductible
Inpatient habilitation services	0% no deductible	30% after deductible	50% after deductible
Inpatient rehabilitation services	0% no deductible	30% after deductible	50% after deductible
Skilled nursing facility care	0% no deductible	30% after deductible	50% after deductible
Outpatient surgery/services	0% no deductible	30% after deductible	50% after deductible
Diagnostic and therapeutic radiology/laboratory and dialysis	0% no deductible	40% after deductible	50% after deductible
Center of Excellence with prior approval by the Co-op	0% no deductible	0% no deductible	50% after deductible
Urgent and Emergency Services			
Urgent care center	0% no deductible	$75 no deductible	50% after deductible
Doctor on Demand	0% no deductible	$20 no deductible	NA
Emergency room	0% no deductible	40% after deductible	40% after deductible
Ambulance, ground and air	0% no deductible	40% after deductible	40% after deductible
Prescription Drug Benefit Prior Authorization May be Required	***If you choose a higher Tier drug when a lower Tier drug is available, you may be subject to additional member responsibility.***		
Preventive Drugs (Tier 5 online search)	0% no deductible	0% no deductible	50% after deductible
Retail Pharmacy Prescriptions (30-day supply)			
Tier 1-Preferred Generic Drug	0% no deductible	10% coinsurance, deductible does not apply	50% after deductible

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Tier 2-Preferred Brand and Non-Preferred Generic Drugs	0% no deductible	25% coinsurance, deductible does not apply	50% after deductible
Tier 3-Non-Preferred Brand Drugs	0% no deductible	35% coinsurance, deductible does not apply	50% after deductible
Tier 4-Non-Preferred Brand Drugs	0% no deductible	45% coinsurance, deductible does not apply	50% after deductible
Mail Order Maintenance (90-day supply)			
Tier 1-Preferred Generic Drug	0% no deductible	10% coinsurance, deductible does not apply	50% after deductible
Tier 2-Preferred Brand and Non-Preferred Generic Drugs	0% no deductible	25% coinsurance, deductible does not apply	50% after deductible
Tier 3-Non-Preferred Brand Drugs	0% no deductible	35% coinsurance, deductible does not apply	50% after deductible
Mental Health, Autism Spectrum Disorder and Substance Use Disorder Services	Prior Authorization May be Required		
	Indian Health Care Provider (IHCP)	Your Cost In-Network	Your Cost Out-Of-Network
Office visits	0% no deductible	$35 no deductible	50% after deductible
Inpatient care	0% no deductible	30% after deductible	50% after deductible
Outpatient care	0% no deductible	30% after deductible	50% after deductible
Doctor on Demand	0% no deductible	$20 no deductible	NA
Residential programs	0% no deductible	30% after deductible	50% after deductible
Other Covered Services		Prior Authorization May be Required	
Durable medical equipment	0% no deductible	30% after deductible	50% after deductible

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Home health	0% no deductible	30% after deductible	50% after deductible
Prosthetics	0% no deductible	30% after deductible	50% after deductible
Transplants	0% no deductible	30% after deductible	50% after deductible
Bariatric Surgery – (One per lifetime)	0% no deductible	30% after deductible	50% after deductible
Pediatric Vision Care Services	*This Vision Care Benefit only applies to Covered Dependents underage 19.*		
	Indian Health Care Provider (IHCP)	Your Cost In-Network	Your Cost Out-of-Network
Vision examination (one per benefit/plan year)	0% no deductible	0% no deductible	25% after deductible
Vision care materials	0% no deductible	See Policy for limitations	
Vision Exam Reimbursement	Reimbursement Maximum		
Vision exam (one per benefit/plan year)	$60		
Dental Exam Reimbursement	Reimbursement Maximum		
Dental exam (one per benefit/plan year)	$100		

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

(1) **Comprehensive Health Insurance Coverage** — Policies of this category are designed to provide to members, coverage for major hospital, medical, and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services, and out-of-hospital care, subject to any deductibles, co-payment and/or coinsurance provisions, or other limitations which may be set forth in the policy.

(2) **Description of Benefits** – The policy provides Comprehensive Health Preferred Provider Organization (PPO) Insurance coverage. You have the option to receive services from an In-Network or an Out-of-Network Provider. Generally, benefits are paid at a higher level when an In-Network Provider is used. The Outline of Coverage reflects the benefits payable when services for Covered Benefits are provided by an In-Network Provider or an Out-of-Network Provider. The Outline of Coverage and the Covered Benefits provided under the Policy are indicated above.

(3) **Out-of-Network Maximum** – Be aware that your actual costs for services provided by an out-of-network provider may exceed this policy's maximum out-of-pocket for out-of-network services because out-of-network providers can bill you for the difference between the amount charged by the provider and the amount allowed by the insurance company. Amounts in excess of the allowed amount are not counted toward the out-of-network deductible or maximum out-of-pocket.

(4) **Prior Approval** – Covered Services may be subject to the prior approval process. Please see the comprehensive policy document for details on what services require prior authorization

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