

Outline of Coverage

HIGH PLAINS INDIVIDUAL SILVER WYOMING 73

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: []

| | In-network | Out-of-network |
|--|------------|----------------|
| Maximum Lifetime Benefit | | |
| Individual (per member) | Unlimited | Unlimited |
| Deductible – Benefit/Plan Year | In-network | Out-of-network |
| Individual (per member) | \$6,700 | \$20,100 |
| Family (per family) | \$13,400 | \$40,200 |
| Out-of-Pocket Limit Per Benefit/Plan Year | In-network | Out-of-network |
| Individual (per member) | \$7,000 | \$21,000 |
| Family (per family) | \$14,000 | \$42,000 |
| Coinsurance | In-network | Out-of-network |
| | 40% | 60% |

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*.

| Covered Benefit | YOUR COST IN-NETWORK | YOUR COST OUT-OF-NETWORK |
|--|-------------------------|-----------------------------|
| Preventive Care Prior Authorization May be Required | | |
| <u>Preventive/Wellness</u> | 0% No deductible | 60% after deductible |

| | | |
|--|----------------------|----------------------|
| Professional Services Prior Authorization May be Required | | |
| Primary care provider | \$40 no deductible | 60% after deductible |
| Specialist office visit | \$75 no deductible | 60% 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.) | \$75 no deductible | 60% after deductible |
| Acupuncture (12 visits per benefit/plan year) | 40% after deductible | 60% after deductible |
| <u>Doctor on Demand</u> | \$20 no deductible | NA |
| Surgeon | 40% after deductible | 60% after deductible |
| Anesthesiologist | 40% after deductible | 60% 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.) | 40% after deductible | 60% after deductible |
| Outpatient rehabilitation services- (40 visits per calendar year for physical therapy and combined 20 visit per calendar year maximum for occupational therapy & speech therapy.) | 40% after deductible | 60% after deductible |
| Chiropractic Services- Maximum number of services per benefit year (20) | \$75 no deductible | 60% after deductible |

| | | |
|---|----------------------|----------------------|
| Hospital/Facility Services Prior Authorization May be Required | | |
| Inpatient room and board | 40% after deductible | 60% after deductible |
| Inpatient habilitation services | 40% after deductible | 60% after deductible |
| Inpatient rehabilitation services | 40% after deductible | 60% after deductible |
| Skilled nursing facility care | 40% after deductible | 60% after deductible |
| Outpatient surgery/services | 40% after deductible | 60% after deductible |

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| | | |
|---|--|----------------------|
| Diagnostic and therapeutic radiology/laboratory and dialysis | 50% after deductible | 60% after deductible |
| Center of Excellence with prior approval by the Co-op | 0% no deductible | 60% after deductible |
| Urgent and Emergency Services | | |
| Urgent care center | \$110 no deductible | 60% after deductible |
| Doctor on Demand | \$20 no deductible | NA |
| Emergency room | 50% after deductible | 50% after deductible |
| Ambulance, ground and air | 50% after deductible | 50% after deductible |
| Prescription Drug Benefit Prior Authorization May be Required | <i>If you choose a higher Tier drug when a lower Tier drug is available, you may be subject to additional member responsibility.</i> | |
| Preventive Drugs (Tier 5 online search) | \$0 no deductible | 60% after deductible |
| Retail Pharmacy Prescriptions (30-day supply) | | |
| Tier 1-Preferred Generic Drug | 15% no deductible | 60% after deductible |
| Tier 2-Preferred Brand and Non-Preferred Generic Drugs | 30% no deductible | 60% after deductible |
| Tier 3-Non-Preferred Brand Drugs | 40% no deductible | 60% after deductible |
| Tier 4-Non-Preferred Brand Drugs | 50% no deductible | 60% after deductible |
| Mail Order Maintenance (90-day supply) | | |
| Tier 1-Preferred Generic Drug | 15% no deductible | 60% after deductible |
| Tier 2-Preferred Brand and Non-Preferred Generic Drugs | 30% no deductible | 60% after deductible |
| Tier 3-Non-Preferred Brand Drugs | 40% no deductible | 60% after deductible |
| | | |

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| Covered Benefit | YOUR COST IN-NETWORK | YOUR COST OUT-OF-NETWORK |
|--|-------------------------------------|-----------------------------|
| Mental Health, Autism Spectrum Disorder and Substance Use Disorder Services Prior Authorization May be Required | | |
| Office visits | \$40 no deductible | 60% after deductible |
| Inpatient care | 40% after deductible | 60% after deductible |
| Outpatient care | 40% after deductible | 60% after deductible |
| Doctor on Demand | \$20 no deductible | NA |
| Residential programs | 40% after deductible | 60% after deductible |
| Other Covered Services | Prior Authorization May be Required | |
| Durable medical equipment | 40% after deductible | 60% after deductible |
| Home health | 40% after deductible | 60% after deductible |
| Prosthetics | 40% after deductible | 60% after deductible |
| Transplants | 40% after deductible | 60% after deductible |
| Bariatric Surgery – (One per lifetime) | 40% after deductible | 60% after deductible |
| Pediatric Vision Care Services <i>This Vision Care Benefit only applies to Covered Dependents under age 19.</i> | | |
| Vision examination (one per benefit/plan year) | 0% no deductible | 25% after deductible |
| Vision care materials | 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.

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- (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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