

## Outline of Coverage

### LINK INDIVIDUAL BRONZE IDAHO NAZC HD

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:** LINK

**Coverage Year:** 2023

**Premium Due Date:** 1<sup>st</sup> day of each month

**Premium:** [ ]

|  | In-network | Out-of-network |
|--|------------|----------------|
| <b>Maximum Lifetime Benefit</b>                  |            |                |
| <b>Individual</b> (per member)                   | Unlimited  | Unlimited      |
| <b>Deductible – Benefit/Plan Year</b>            | In-network | Out-of-network |
| <b>Individual</b> (per member)                   | \$0        | \$0            |
| <b>Family</b> (per family)                       | \$0        | \$0            |
| <b>Out-of-Pocket Limit Per Benefit/Plan Year</b> | In-network | Out-of-network |
| <b>Individual</b> (per member)                   | \$0        | \$0            |
| <b>Family</b> (per family)                       | \$0        | \$0            |
| <b>Coinsurance</b>                               | In-network | Out-of-network |
|  | 0%         | 0%             |

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<br>IN-NETWORK | YOUR COST<br>OUT-OF-NETWORK |
|---|-------------------------|-----------------------------|
| <b>Preventive Care</b> Prior Authorization May be Required                            |                         |                             |
| <a href="#"><u>Preventive/Wellness</u></a>  | No charge               | No charge                   |
| <b>Professional Services</b> Prior Authorization May be Required                      |                         |                             |
| <b>Primary care provider</b>  | No charge               | No charge                   |
| <b>Specialist office visit</b>  | No charge               | No charge                   |
| <b>Therapy office visit -PT, OT, ST</b><br>(combined 20 visits per benefit/plan year) | No charge               | No charge                   |
| <b>Acupuncture</b> (12 visits per benefit/plan year)                                  | No charge               | No charge                   |
| <a href="#"><u>Doctor on Demand</u></a>   | No charge               | NA                          |
| <b>Surgeon</b>  | No charge               | No charge                   |
| <b>Anesthesiologist</b>   | No charge               | No charge                   |
| <b>Outpatient habilitation services</b><br>(combined 20 visits per benefit/plan year) | No charge               | No charge                   |
| <b>Outpatient rehabilitation services</b> (combined 20 visits per benefit/plan year)  | No charge               | No charge                   |
| <b>Chiropractic Services-</b> Maximum number of services per benefit year (20)        | No charge               | No charge                   |
| <b>Hospital/Facility Services</b> Prior Authorization May be Required                 |                         |                             |
| <b>Inpatient room and board</b>   | No charge               | No charge                   |
| <b>Inpatient habilitation services</b>  | No charge               | No charge                   |
| <b>Inpatient rehabilitation services</b>  | No charge               | No charge                   |
| <b>Skilled nursing facility care</b> (30 day limit per plan/benefit year)             | No charge               | No charge                   |
| <b>Outpatient surgery/services</b>  | No charge               | No charge                   |
| <b>Diagnostic and therapeutic radiology/laboratory and dialysis</b>                   | No charge               | No charge                   |
| <b>Urgent and Emergency Services</b>  |                         |                             |

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|  |  |                                     |
|--|--|-------------------------------------|
| Urgent care center   | No charge  | No charge                           |
| <a href="#">Doctor on Demand</a>   | No charge  | NA                                  |
| Emergency room   | No charge  | No charge                           |
| Ambulance, ground, and air   | No charge  | No charge                           |
| Prescription Drug Benefit<br>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> |                                     |
| <b>Preventive Drugs</b> (Tier 5 online search)   | No charge  | No charge                           |
| <b>Retail Pharmacy Prescriptions</b> (30-day supply)   |  |                                     |
| Tier 1-Preferred Generic Drug  | No charge  | No charge                           |
| Tier 2-Preferred Brand and Non-Preferred Generic Drugs   | No charge  | No charge                           |
| Tier 3-Non-Preferred Brand Drugs   | No charge  | No charge                           |
| Tier 4-Non-Preferred Brand Drugs   | No charge  | No charge                           |
| <b>Mail Order Maintenance</b> (90-day supply)  |  |                                     |
| Tier 1-Preferred Generic Drug  | No charge  | No charge                           |
| Tier 2-Preferred Brand and Non-Preferred Generic Drugs   | No charge  | No charge                           |
| Tier 3-Non-Preferred Brand Drugs   | No charge  | No charge                           |
| <b>Covered Benefit</b>   | <b>YOUR COST<br/>IN-NETWORK</b>  | <b>YOUR COST<br/>OUT-OF-NETWORK</b> |
| Mental Health, Autism Spectrum Disorder and Substance Use Disorder Services<br>Prior Authorization May be Required |  |                                     |
| <b>Office visits</b>   | No charge  | No charge                           |
| <b>Inpatient care</b>  | No charge  | No charge                           |
| <b>Outpatient care</b>   | No charge  | No charge                           |

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|   |   |           |
|---|---|-----------|
| <a href="#"><u>Doctor on Demand</u></a>               | No charge   | NA        |
| <b>Residential programs</b>                           | No charge   | No charge |
| <b>Other Covered Services</b>                         | Prior Authorization May be Required   |           |
| <b>Durable medical equipment</b>                      | No charge   | No charge |
| <b>Home health</b> (180 days per plan/benefit year)   | No charge   | No charge |
| <b>Prosthetics</b>                                    | No charge   | No charge |
| <b>Transplants</b>                                    | No charge   | No charge |
| <b>Pediatric Vision Care Services</b>                 | <i>This Vision Care Benefit only applies to Covered Dependents underage 19.</i> |           |
| <b>Vision examination</b> (one per benefit/plan year) | No charge   | No charge |
| <b>Vision care materials</b>                          | See Policy for limitations  |           |
| <b>Vision Exam Reimbursement</b>                      | Reimbursement Maximum   |           |
| <b>Vision exam</b> (one per benefit/plan year)        | \$60  |           |
| <b>Dental Exam Reimbursement</b>                      | Reimbursement Maximum   |           |
| <b>Dental exam</b> (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 (POS) 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

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policy document for details on what services require prior authorization.

Rating Factors and Trend: The following factors are used in setting rates: regional information and assumptions regarding our expected population, the projected claims, income, and enrollment for the next 12 -month rating period, projected expenses for the plan of the next rating period, and/or age of the application or subscriber, industry, and risk characteristics. The trend of premium increases on average during the preceding five years is:

2018 (4.5%), 2019(11%), 2020(-11%), 2021 (-12%), 2022(1%)

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