MOUNTAIN HEALTH CO-OP

Outline of Coverage

ROCKY MOUNTAIN SILVER STANDARD 94

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: ROCKY MOUNTAIN **Coverage Year**: 2024
State: Montana **Network:** Individual
Premium Due Date: [ ] **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)	$0	$2,000
Family (per family)	$0	$4,000
Out-of-Pocket Limit Per Benefit/Plan Year	**In-network**	**Out-of-network**
Individual (per member)	$1,800	$5,100
Family (per family)	$3,600	$10,200
Coinsurance	**In-network**	**Out-of-network**
	25%	45%

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 see section 6 of your policy document.

Covered Benefit	YOUR COST IN-NETWORK	YOUR COST OUT-OF-NETWORK
Preventive Care	**Prior Authorization May be Required**	
Preventive/Wellness	No Charge	45% After deductible
Professional Services*		
Primary care office visit	0%	45% After deductible
Specialist office visit	$10	45% After deductible
Therapy office visit - PT, OT, ST	0%	45% After deductible
Doctor on Demand	$10	Not Applicable
Surgeon	25%	45% After deductible
Anesthesiologist	25%	45% After deductible
Outpatient habilitation services	25%	45% After deductible
Outpatient rehabilitation services	25%	45% After deductible
Chiropractic Services *(20 visits per year)*	$10	45% After deductible
Hospital/Facility Services*		
Inpatient room and board	25%	45% After deductible
Inpatient habilitation services	25%	45% After deductible
Inpatient rehabilitation services	25%	45% After deductible
Skilled nursing facility care *(60 days per year)*	25%	45% After deductible
Outpatient surgery/services	25%	45% After deductible
Diagnostic and therapeutic radiology/laboratory and dialysis	25%	45% After deductible
Center of Excellence with prior approval by the Co-op	0%	NA
Urgent and Emergency Services		
Urgent care center	$5	45% After deductible
Doctor on Demand	$10	N/A
Emergency room	25%	25% After Deductible
Ambulance; ground and air	25%	25% After Deductible

Prescription Drug Benefit*	*If you choose a higher Tier drug when a lower Tier drug is available, you may be subject to additional member responsibility.*

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$0 Out of Pocket Prescriptions (Tier 5 online search)	No Charge	N/A
Retail Pharmacy Prescriptions - (30-day supply)		
Tier 1-Preferred Generic Drug	0%	45% After deductible
Tier 2-Preferred Brand and Non-Preferred Generic Drugs	$15	45% After deductible
Tier 3-Non-Preferred Brand Drugs	$50	45% After deductible
Tier 4-Specialty Drugs	$150	45% After deductible
Mail Order Maintenance - (90-day supply)		
Tier 1-Preferred Generic Drug	0%	N/A
Tier 2-Preferred Brand and Non-Preferred Generic Drugs	$30	N/A
Tier 3-Non-Preferred Brand Drugs	$100	N/A
Mental Health, Autism Spectrum Disorder and Substance Use Disorder Services*		
Primary care office visit	0%	45% After deductible
Doctor on Demand	$10	N/A
Residential programs	25%	45% After deductible
Other Covered Services*		
Durable medical equipment	25%	45% After deductible
Home health *(180 visits per year)*	25%	45% After deductible
Prosthetics	25%	45% After deductible
Transplants	25%	45% After deductible
Pediatric Vision Care Services	*This Vision Care Benefit only applies to Covered Dependents under age 19.*	
Pediatric Vision examination (one per benefit/plan year)	0%	25% after deductible
Vision care materials	See Policy for limitations	
Vision Exam Reimbursement	Reimbursement Maximum	
Vison exam (one per benefit/plan year)	$60	
Dental Exam Reimbursement	Reimbursement Maximum	
Dental exam (one per benefit/plan year)	$100	

***Prior Authorization May be Required**

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

(1) **Comprehensive Health Insurance Coverage** — Policies of this category are designed to provide to members,

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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, section 6, Utilization Review Management for details on what services require prior authorization.

(5)

Rating Factors and Trend: The following factors are used in setting rates: region al 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 premiumincreases on average during the preceding five years is:

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