MOUNTAIN HEALTH CO-OP

Outline of Coverage

Ronan School District

Plan G Gold CO-OP Plus

Benefit Plan Year	September 1, 2024 – August 31, 2025	
Benefit Accrual Period	Plan Year	
Maximum Lifetime Benefit	In-network	Out-of-network
Individual (per member)	Unlimited	Unlimited
Deductible	In-network	Out-of-network
Individual (per member) **Family** (per family)	$700 $1,400	$1,400 $2,800
Out-of-Pocket Limit Per	In-network	Out-of-network
Individual (per member) **Family** (per family)	$4,500 $9,000	$7,500 $15,000
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 requirements, please see section 6, Utilization Review, Management Program of your policy document.

Covered Benefit	YOUR COST IN-NETWORK	YOUR COST OUT-OF-NETWORK
Preventive Care		
Preventive/Wellness	No Charge	50% After Deductible

Professional Services*		
Primary care office visit – Tier 1 Provider	$10 Copayment	N/A
Primary care office visit – Tier 2 Provider	$20 Copayment	50% After Deductible
Specialist office visit	$40 Copayment	50% After Deductible
Therapy office visit - PT, OT, ST	30% After Deductible	50% After Deductible
Doctor on Demand	No Charge	N/A
Surgeon	30% After Deductible	50% After Deductible
Anesthesiologist	30% After Deductible	50% After Deductible
Outpatient habilitation services	30% After Deductible	50% After Deductible
Outpatient rehabilitation services	30% After Deductible	50% After Deductible
Chiropractic Services *(20 visits per year)*	30% After Deductible	50% After Deductible
Hospital/Facility Services*		
Inpatient room and board	30% After Deductible	50% After Deductible
Inpatient habilitation services	30% After Deductible	50% After Deductible
Inpatient rehabilitation services	30% After Deductible	50% After Deductible
Skilled nursing facility care *(60 days per year)*	30% After Deductible	50% After Deductible
Outpatient surgery/services	30% After Deductible	50% After Deductible
Diagnostic and therapeutic radiology/laboratory and dialysis	30% After Deductible	50% After Deductible
Center of Excellence with prior approval by the Co-op	30% After Deductible	50% After Deductible
Urgent and Emergency Services		
Urgent care center	$200 Copay After Deductible	$200 Copay After Deductible
Doctor on Demand	No Charge	N/A

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Emergency room	$200 Copay After Deductible	$200 Copay After Deductible
Ambulance; ground and air	$200 Copay After Deductible	$200 Copay 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.*	
$0 Out of Pocket Prescriptions (Tier 5 online search)	No Charge	N/A
Retail Pharmacy Prescriptions - (30-day supply)		
Tier 1-Preferred Generic Drug	$10 Copayment	50% After Deductible
Tier 2-Preferred Brand and Non-Preferred Generic Drugs	$25 Copayment	50% After Deductible
Tier 3-Non-Preferred Brand Drugs	$65 Copayment	50% After Deductible
Tier 4-Non-Preferred Brand Drugs (Specialty Drugs)	$80 Copayment	N/A
Mail Order Maintenance - (90-day supply)		
Tier 1-Preferred Generic Drug	$20 Copayment	N/A
Tier 2-Preferred Brand and Non-Preferred Generic Drugs	$50 Copayment	N/A
Tier 3-Non-Preferred Brand Drugs	$110 Copayment	N/A
Mental Health, Autism Spectrum Disorder and Substance Use Disorder Services*		
Office visits	Tier 1: First Visit $0, then $10 Copayment Tier 2: First Visit $0, then $20 Copayment	50% After Deductible
Inpatient care	30% After Deductible	50% After Deductible
Outpatient care	30% After Deductible	50% After Deductible
Doctor on Demand	No Charge	N/A
Residential programs	30% After Deductible	50% After Deductible
Other Covered Services*		
Durable medical equipment	30% After Deductible	50% After Deductible
Home health *(180 visits per year)*	30% After Deductible	50% After Deductible
Prosthetics	30% After Deductible	50% After Deductible
Transplants	30% After Deductible	50% After Deductible
Pediatric Vision Care Services	*This Vision Care Benefit only applies to Covered Dependents under age 19.*	

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Vision examination *(One per year)*	No Charge	25% After Deductible
Vision care materials *(See policy for limitations)*	No Charge	25% After Deductible
Vision Exam Reimbursement	Reimbursement Maximum	
Vison examination *(One per year)*	$60	
Dental Exam Reimbursement	Reimbursement Maximum	
Dental exam/cleaning *(One per year)*	$100	

*Prior authorization may be required.

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