MOUNTAIN HEALTH CO-OP

OUTLINE OF COVERAGE

Individual Link Comprehensive Health Insurance Policy

Benefit Plan: **LINK SILVER OPTION 2 94**

Policy Effective Date: January 1, 2021

Type of Coverage: Individual/Family

Mode of Payment: Monthly

Benefit Period: Calendar Year

Premium Due Date: The first day of each month

THE POLICY PROVIDES A NETWORK THROUGH WHICH INSUREDS CAN RECEIVE SERVICES FROM IN-NETWORK PROVIDERS. IT IS THE INSURED'S RESPONSIBILITY FOR PAYMENT OF BILLED CHARGES BEYOND THE IN-NETWORK CHARGES WHEN THE INSURED USES THE SERVICES OF AN OUT-OF-NETWORK PROVIDER.

(1) **Read Your Policy Carefully** — This outline of coverage provides a very brief description of the 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 your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY.

(2) **Comprehensive Health Insurance Coverage** — Policies of this category are designed to provide to persons insured, 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 provisions, or other limitations which may be set forth in the policy.

(3) **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 a Preferred Provider is used. The Outline of Coverage reflects the benefits payable when services for Covered Benefits are provided by a Preferred Provider or a Non-Preferred Provider. The Outline of Coverage and the Covered Benefits provided under the Policy are indicated below in this section.

(4) *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.

Mountain Health Co-op does not discriminate on the basis of basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation, or health status in the administration of the plan, including enrollment and benefit determinations.

BENEFIT INFORMATION	IN-NETWORK	OUT-OF-NETWORK *See Out of Network Maximum on page one*
Maximum Lifetime Benefit • Per Insured	Unlimited	Unlimited
Deductible		
• Individual Deductible (*per Insured per Calendar Year)*	$0	$0
• Family Deductible *(per family per Calendar Year)*	$0	$0
Annual Out-of-Pocket Maximum		
• Individual Annual Out-of-Pocket Maximum *(per Insured per Calendar Year)*	$800	$1,600
• Family Annual Out-of-Pocket Maximum *(per family per Calendar Year)*	$1,600	$3,200
Coinsurance	20%	30%

BENEFITS

This Policy will pay Covered Medical Expenses incurred for Covered Benefits provided in *Section 5, Covered Benefits*: (1) based on the Allowable Fee; and (2) unless otherwise indicated below, subject to the 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.

COVERED BENEFIT	YOUR COST IN-NETWORK	YOUR COST OUT-OF NETWORK *See Out of Network Maximum on page one*
All Covered Benefits shown in Section 5, unless otherwise specified below in this Outline of Coverage	20% after Deductible	30% after Deductible
Daily Hospital Room and Board	20% after Deductible	30% after Deductible
Miscellaneous Hospital Services	20% after Deductible	30% after Deductible
Surgical Services	20% after Deductible	30% after Deductible
Anesthesia Services	20% after Deductible	30% after Deductible
In-Hospital Medical Services	20% after Deductible	30% after Deductible
Out-of-Hospital Care	20% after Deductible	30% after Deductible
Chemical Dependency • Inpatient/Outpatient Facility • Office Visit	20% after Deductible $10 Copay	30% after Deductible 30% after Deductible
Chiropractic Services • Maximum Number of Office Visits per Calendar Year – 20 visits	20% after Deductible	30% after Deductible
Convalescent Home Services (Skilled Nursing) • Maximum Number of Days per Calendar Year – 30 days	20% after Deductible	30% after Deductible
Durable Medical Equipment • Rental (up to the purchase price), Purchase and Repair and Replacement of Durable Medical Equipment *Preauthorization is required for original purchase or replacement of Durable Medical Equipment over $1000*	20% after Deductible	30% after Deductible

COVERED BENEFIT	YOUR COST IN-NETWORK	YOUR COST OUT-OF NETWORK *See Out of Network Maximum on page one*
Emergency Services	30% after Deductible	30% after Deductible
Home Health Care Services • Maximum Number of Home Visits per Calendar Year 120 day maximum	20% after Deductible	30% after Deductible
Hearing Aids (*This benefit only applies to insured underage children under age 19)*	20% after Deductible	30% after Deductible
Laboratory Services	30% after Deductible	30% after Deductible
Mental Health Services • Inpatient/Outpatient Facility • Office Visit	20% after Deductible $10 Copay	30% after Deductible 30% after Deductible
Physician Medical Services • Physician Office Visits (Non-Specialist)	$10 Copay	30% after Deductible
• Physician Specialist Visits	$50 Copay	30% after Deductible
Prescription Drugs Benefit • **Retail Pharmacy Prescriptions** 30-day supply/per drug. • Tier 0-Preventive Drugs, including contraceptives • Tier 1-Preferred Generic Drug • Tier 2-Preferred Brand and Non-Preferred Generic Drugs • Tier 3-Non-Preferred Brand Drugs • Tier 4-Preferred Specialty Drugs **If you choose a higher Tier drug when a lower Tier drug is available, you must pay an ancillary charge in addition to the deductible and/or coinsurance, as applicable.*	 $0 $5 Copay 20% after Deductible 25% after Deductible 25% after Deductible	 $0 30% after Deductible 30% after Deductible 30% after Deductible 30% after Deductible
• **Mail Order Maintenance** 90-day supply/per drug • Tier 0-Preventive Drugs, including contraceptives • Tier 1-Preferred Generic Drugs • Tier 2-Preferred Brand and Non-Preferred Generic Drugs • Tier 3-Non-Preferred Brand Drugs • Tier 4-Preferred Specialty Drugs **If you choose a higher Tier drug when a lower Tier drug is available, you must pay an ancillary charge in addition to the deductible and/or coinsurance, as applicable.*	 $0 $10 Copay 20% after Deductible 25% after Deductible N/A	 $0 30% after Deductible 30% after Deductible 30% after Deductible N/A

COVERED BENEFIT	YOUR COST IN-NETWORK	YOUR COST OUT-OF NETWORK *See Out of Network Maximum on page one*
Preventive Health Care Services	100% Covered, Deductible and Annual Out-of-Pocket Maximum do not apply	30% after Deductible
Prostheses Benefit (Non-Dental) • Rental (up to the purchase price) Purchase, Repair, Replacement of Prosthetics • Preauthorization required for the original purchase or replacement of prosthetics over $1000	20% after Deductible	30% after Deductible
Therapeutic Services Habilitative –	20% after Deductible	30% after Deductible
Rehabilitation Outpatient: Limit of 20 visits per year for service PT, OT and ST	$50 Copay	30% after Deductible
Transplant Services	20% after Deductible	30% after Deductible

OUTLINE OF COVERAGE (continued)

Individual LINK Comprehensive Health Insurance Policy

COVERED BENEFIT	YOUR COST IN-NETWORK	YOUR COST OUT-OF NETWORK
Urgent Care Benefit – Doctor on Demand Telemedicine	$75 copay	NA
Urgent Care Benefit - At Urgent Care Clinic	$75 copay	30% after deductible
Vision Exam Reimbursement	100% Covered $60 limit	100% Covered $60 limit
Vision Care Benefit – Pediatric Vision Care Services *This Vision Care Benefit only applies to Insured Dependent Children under age 19.*		
• **Vision Care Services** • **Vision Examination** *Frequency of Services:* One Vision Examination per Insured Dependent Child per Calendar Year	100% Covered	25%

• **Vision Care Materials**
  • **Lenses**
  • Single Vision
  • Bifocal
  • Trifocal
  • Lenticular
 	
**Coverage includes lenses in polycarbonate, plastic or glass, scratch resistant or UV coatings also covered.*
 	
Frequency of Services: One set of lenses per Insured Dependent Child per Calendar Year
	
	100% Covered*
	100% Covered*
	100% Covered*
	100% Covered*
		
		25%
		25%
		25%
		25%

• **Vision Care Materials** • **Frames** *Frequency of Services:* One frame per Insured Dependent Child per Calendar Year. Frame selection will be from a Pediatric Exchange Collection.	100% Covered	25%

COVERED BENEFIT	YOUR COST IN-NETWORK	YOUR COST OUT-OF NETWORK
• **Contact Lenses**		
• Necessary Professional Fees and Materials	100% Covered***	25%***
• Elective Professional Fees** and Materials	100% Covered***	25%***

***15% discount applies to the Provider's usual and customary professional fees for contact lens evaluation and fitting*

****The following service limitations apply to In-Network benefits for Contact Lenses: (1) Standard (one pair annually) = 1 contact lens per eye (total 2 lenses); (2) Monthly (six-month supply) = 6 lenses per eye (total 12 lenses); (3) Bi-weekly (3-month supply) = 6 lenses per eye (total 12 lenses); and (4) Dailies (one month supply) = 30 lenses per eye (total 60 lenses).*

EXCLUSIONS AND LIMITATIONS

All benefits provided under this Policy are subject to the exclusions and limitations in this Section and as stated under Section 5, Covered Benefits. No benefits will be paid under this Policy that are incurred by or results from any of the following.

1. Sanitarium care, custodial care, rest cures, custodial care or convalescent care to help the Covered Person with daily living tasks. Such tasks include, but limited to, the following:
   (a) walking; (b) getting in and out of bed; (c) bathing; (d) dressing; (e) feeding; (f) using the toilet; (g) preparing special diets; or (h) supervision of medication which is usually self-administered and does not require the continuous attention of medical personnel.

2. An Illness or Injury arising out of or in the course of doing any job or work for wage or profit, or Illness covered by any Workers' Compensation Law or Act, occupational disease laws, or similar legislation, including employees' compensation or liability laws of the United States. This exclusion applies to all services and supplies provided to treat such Illness or Injury even though: (a) coverage under the government legislation provides benefits for only a portion of the services incurred; (b) the employer has failed to obtain such coverage required by law; (c) the Covered Person waives the Covered Person's rights to such coverage or benefits; (d) the Covered Person fails to file a claim within the filing period allowed by law for such benefits; (e) the Covered Person fails to comply with any other provision of the law to obtain coverage or benefits; and (f) the Covered Person was permitted to elect not to be covered by the Worker's Compensation Act but failed to properly make such election effective.

This exclusion will not apply if the Covered Person is permitted by statute not be covered and the Covered Person elects not to be covered by the Workers' Compensation Act, occupational disease laws, or liability laws.

This exclusion will not apply if the Covered Person's employer was not required and did not elect to be covered under any Workers' Compensation, occupational disease laws or employer's liability acts of any state, country, or the United States.

3. Services, supplies, drugsanddevices whichthe Covered Personis entitledtoreceiveor does receive TRICARE, the Veteran's Administration (VA), and Indian Health Services butnot Medicaid.

Note: Under some circumstances, the law allows certain governmental agencies to recover for services rendered to the Covered Person. When such a circumstance occurs, the Covered Person will receive an explanation of benefits.

4. War, or act of war, whether declared or not, rebellion, armed invasion, or insurrection;

5. Service in the Armed Forces or any auxiliary units of the Armed Forces;

6. Any loss for which a contributing cause was commission by the Covered Person of a felony, or attempt to commit a felony. This exclusion does not apply if the loss is related to being a victim of domestic violence.

7. Dental care and treatment except for such care or treatment due to accidental Injury to sound natural teeth within 12 months of the accident and except for dental care or treatment necessary due to congenital disease or anomaly;

8. Vision services, including, but not limited to, (a) fitting of eyeglasses or contact lenses; (b) purchase of eyeglasses and contact lenses; (c) Lasik surgery; or (d) radial keratotomy (refractive keratoplasty or other surgical procedures to correct myopia/astigmatism). This exclusion does not apply to the Pediatric Vision Care benefit provided under this Policy or to the preventive eye exam benefit, if any, provided under this Policy;

9. Hearing aids and examinations for the prescription or fitting of hearing aids except as specified as a Covered Service in the Contract;

10. Cosmetic Surgery, unless (a) it is Medically Necessary; or (b) it is reconstructive surgery. Such reconstructive surgery must be: (a) incidental to or following surgery resulting from trauma, infection or other diseases of the involved part; and (b) because of congenital disease or anomaly of a covered Dependent Child which has resulted in a functional defect;

11. Services, supplies, drugs and devices for the treatment of illness, injury, or complications, resulting from services that are not Covered Benefits, except for any services, supplies, drugs and devices which are incurred in connection with an Approved Clinical Trial;

12. Foot care, including but limited to: (a) treatment or removal of corns and callosities; (b) hypertrophy, hyperplasia of the skin or subcutaneous tissues; (c) cutting or trimming toenails; (d) any Treatment of congenital flat foot; (e) injections and nonsurgical Treatment of acquired flat foot, fallen arches, or chronic foot strain; (f) any Treatment of flat foot purely for the purpose of altering the foot's contour where no medicine or functional impairment exists; (g) orthotic appliances; (h) impression casting for orthotic appliances; (i) padding and strapping; or (j) fabrication;

13. Foot orthotic appliance provided for the treatment of any medical condition;

14. Treatment for infertility and fertilization procedures, including, but not limited to, ovulation induction procedure and pharmaceuticals, artificial insemination, invitro fertilization, embryo transfer and storage or similar procedures, including but not limited to laboratory services, radiology services or similar services, drugs or devices related to treatment for fertility or fertilization procedures;

15. Continuous passive motion devices;

16. Behavioral Health and Substance Abuse or Addiction services and treatments not recognized by the American Psychiatric and American Psychological Association;

17. TENS units;

18. Treatment provided in a government hospital, except Montana residents who are confined in state medical institutions; benefits provided under Medicare or other governmental program (except Medicaid);

19. Services rendered and separately billed by employees of hospitals, laboratories or other institutions;

20. Services performed by You or a member of Your Immediate Family.

21. Services for which there is no legal obligation for the Covered Person to pay or for which no charge would be made if insurance did not exist, unless such charge is regularly and customarily made in similar amount by the provider of such to other non-indigent patients, or unless, in either case, We are required by law to pay to the Government of the United States;

22. Nonsurgical Treatment for malocclusion of the jaw, including services for temporomandibular joint dysfunction, anterior or internal dislocation, derangements and myofascial pain syndrome, orthodontics (dentofacial orthopedics), orrelatedappliances;

23. Private duty nursing;

24. Any expenses, procedures or services related to Surrogate pregnancy, delivery or donor eggs.

25. Services, supplies, drugs and devices related to in vitro fertilization;

26. Reversal of an elective sterilization;

27. For reversals or revisions of Surgery for obesity, except when required to correct an immediately life- endangering condition when the initial surgery was within the past 30 days.

28. Abortion (*except when the life of the woman is endangered for reasons caused by or arising from the pregnancy or when the pregnancy is the result of an act of rape or incest*)

29. Transplants of a non-human organ or artificial organ transplant;

30. Any services, supplies, drugs and devices which are: (a) an investigational/Experimental Service/Technology; (b) not accepted medical practice; (c) not a Covered Medical Expense; (d) not Medically Necessary and (e) not covered under our Medical Policy. We may consult with Physicians or national medical specialty organizations for advice determining whether the service or supply is accepted-medical practices;

31. For travel by the Covered Person or a provider except as allowed under this Policy;
32. Orthodontics;
33. Services, supplies and devices relating to: (a) Holistic Medicine; (b) Holistic Healing; (c) Reiki; (d) Medical Herbalism; (e) Natural Healing; (f) acupressure; (g) homeopathic treatments; (h) Rolfing; and other forms of Complementary and Alternative Medical treatments or therapy;
34. Services, supplies and devices relating to any of the following treatments or related procedures: (a) religious counseling;(b) self-help programs;
35. Vitamins. NOTE: Certain vitamins may be covered for specific conditions in accordance with Medical Policy;
36. Food supplements and/or medical foods, except when used for Inborn Errors of Metabolism or Enteral Nutrition services as defined in the Medial Policy;
37. Services, supplies, drugs and devices for weight reduction or weight control, whether rendered for weight control or any other condition. This Exclusion does not include intensive behavioral dietary counseling for adult patients when services are provided by a Physician, Physician Assistant or Advanced Nurse Practitioner;
38. Education services, unless otherwise specified as a Covered Benefit, or tutoring services;
39. Any services, supplies, drugs and devices primarily for personal comfort, hygiene, or convenience which are not primarily medical in nature;
40. Computerized items including, but not limited to, the following: (a) durable medical equipment; (b) prosthetic limbs; and (c) communication devices. Payment for deluxe prosthetics and computerized limbs will be based on the Allowable Fee for a standard prosthesis;
41. Applied Behavior Analysis (ABA) services, except as specifically included in this Policy under the Autism Spectrum Disorders;
42. Services, supplies, drugs and devices which are not listed as a Covered Benefit as provided in this Policy; or
43. All services, supplies, drugs and devices provided to treat any Illness or Injury arising out of employment as an athlete;
44. For any of the following: (a) For appliances, splints, or restorations necessary to increase vertical tooth dimensions or restore the occlusion, except as specified as a Covered Service in this Policy; (b) for orthognathic Surgery, including services and supplies to augment or reduce the upper or lower jaw; (c) for implants in the jaw; for pain, treatment, or diagnostic testing or evaluation related to the misalignment or discomfort of the temporomandibular joint (jaw hinge), including splinting services and supplies; (d) for alveolectomy or alveoloplasty when related to tooth extraction;

45. Services, supplies, drugs or devices provided before the Policy Effective Date of coverage or after the termination of coverage;

46. Any service, supply, drug or devices excluded in any other section of this Policy.

47. Charges associated with health clubs.

48. Any service, supply, drug, device or medical expense not provided by a Covered Provider.

49. Non-Emergent services, supplies, drugs, devices or medical expense provided outside the Untied States.

50. Services, supplies, drugs, devices or medial expenses which are not Covered Benefits, not Covered Medical Expenses, or for which benefit maximums have been reached.

51. Services, supplies, drugs, devices or medical expenses not submitted within twelve (12) months after received or provided.

- SPANISH: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-447-2900.
- CHINESE: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-447-2900.
- SERBO-CROATION: U ovom obavještenju su sadržane važne informacije. U ovom obavještenju su sadržane važne informacije o Vašoj prijavi ili osiguranju preko MHC. Pogledajte nalaze li se u ovom obavještenju nekiklljučni datumi. Možda ćete morati poduzeti određenje radnje u datom roku kako biste i dalje zadržali svoje osiguranje ili pomoć pri plaćanju.Imate pravo da ove informacije, kao i pomoć, dobijete besplatno na svom jeziku. Nazovite 1-855-447-2900.
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- VIETNAMESE: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-447-2900.
- ARABIC: ملحوظة: إذا كنت تتحدث يحوي هذا ا, شعار معلومات هامة. يحوي هذا ا, شعار معلومات مهمة بخصوص طلبك الحصول على التغطية من خ • ل ابحث عن التواريخ اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-855-447-2900 (رقم هاتف الصم والبكم: 855-447-2900.)
- GERMAN: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-447-2900.
- TAGALOG: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-447-2900.
- RUSSIAN: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-447- 2900.
- FRENCH: ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-447- 2900.
- ITALIAN: ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-447-2900.

- JAPANESE: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-855-447-2900（TTY:1-855-447-2900） まで、お電話にてご連絡ください。
- THAI: เรยน: ถา้ คณพดู ภาษาไทยคุณสามารถใชบรกิ ารชว่ ยเหลอื ทางภาษาไดฟ้ รี โทร 1-855-447-2900 (TTY: 1-855-447-2900).
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- SUDANIC-FULFULDE: Anndinoore nde’e e woodi habaru kimminiiɗum. TAnndinoore nde’e e woodi habaru kimminiiɗum dow ɗereewol tefal maaɗamaaɗa malla ko yaali dow laawol MHC. Maanda nyalaaɗe lewru nder anndinoorende’e. Teema a giɗeteeɗo ngaɗa goɗɗum bako goɗɗe nyalaaɗe ngam ko yaali njamu maaɗa malla walla dow njobdi. Hakke maaɗa annda habaru ngu’u ewalliinde nder wolde maaɗa naa maa a yoɓii. Noddu 1-855-447-2900.
- UKRAINIAN: УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-855-447-2900 (телетайп: 1-855-447-2900).
- NEPALI: ध्यान दनिुहोस:् तपाइलें नेपाली बोल्नुहुन्छ भने तपाईंको ननमत्तत भाषा सहायता सेवाहरू ननःशुल्क रूपमा उपलब्ध छ । फोन गनहुु ोस ् 1-855-447- 2900 (दिदिवाई: 1-855-447-2900)
- ANTU: ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona 1-855-447-2900 (TTY: 1- 855-447-2900).
- FARSI: توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-855-447-2900 (TTY: 1-855-447-2900) تماس بگیرید.
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- PENNSYLVANIA DUTCH: Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-855-447-2900.