

**Quick Reference Mountain Lakes Cares Summary Plan**  
**\$2,000 80%/50% OV: \$25/\$60 Rx: \$10/\$30/\$60**  
**PPO (Preferred provider organization)**

**Schedule of Benefits**

Deductibles, Coinsurance and Maximums	MLMC Facility and Providers	In-Network Benefit	Out-of-Network Benefit
Calendar Year Deductible – Individual – Family	\$0	\$2,000 \$5,000	\$5,000 \$10,000
Coinsurance	Plan pays 100%/80%	Plan pays 80% after deductible	Plan pays 50% after deductible
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Out-of-Pocket Calendar Year Maximum – Individual – Family	\$5,000 \$10,000	\$5,000 \$10,000	Unlimited Unlimited

- ☐ All of co-pays, co-insurance, and deductible are applied towards the individual and family Out of Pocket.
- ☐ Out of pocket expenses are capped at \$5,000 per individual and \$10,000 per family annually.
- ☐ All out-of-network co-pays, co-insurance, and out-of-pocket expenses are applied towards the in-network maximum limits.
- ☐ In-network out-of-pocket expenses are not applied toward the out-of-network, out-of-pocket maximum limits.
- ☐ In-network hospitals: MLMC Facilities, Health Partners/PHCS.
- ☐ In-network Primary Care and Specialty Care providers: MLMC Owned providers, Health Partners/PHCS.
- ☐ **Please note that Ancillary Providers (Anesthesiologist, Radiologist, Pathologist, etc.) not employed by MLMC are paid under the In-Network column subject to the deductible and coinsurance.**

Covered Services		In-Network Benefit ***** Member Pays *****	Out-of-Network Benefit ***** Member Pays *****
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**Preventive Care and Services**

Preventive Care Services are those that meet the requirements of federal and state law, including certain screenings, immunizations, and physician visits.

☐ Well-childcare, immunizations, vaccines	No Cost	No cost	Member pays deductible then 50%
☐ Annual adult health examinations and physicals	No Cost	No cost	Member pays deductible then 50%
☐ Annual gynecology examination and mammograms	No Cost	No cost	Member pays deductible then 50%
☐ Annual prostate screening	No Cost	No cost	Member pays deductible then 50%

**Primary Care Physician (PCP) Services**

Services performed AND billed in a physician's office

☐ Office Visit (including diagnostic x-rays and laboratory performed in physician's office) (See Mental Health for separate co-pay information)	No Cost (excluding wt mgmt and inj at ML Rural Clinic)	\$25 Co-pay	Member pays deductible then 50%
☐ <b>Specialist Office Visit</b> (including diagnostic x-rays and laboratory performed in physician's office) (See Mental Health for separate co-pay information)	No Cost	\$60 Co-pay	Member pays deductible then 50%
☐ Surgery in a physician's office	No Cost	Member pays deductible then 20%	Member pays deductible then 50%
☐ Allergy care (testing, serum, and allergy shots)	No Cost	Member pays deductible then 20%	Member pays deductible then 50%
☐ Maternity physician services (prenatal, delivery, postpartum)	No Cost	Member pays deductible then 20%	Member pays deductible then 50%

**Emergency Room Services**

☐ Life-threatening illness or serious accidental injury	No Cost	Member pays \$200 Co-pay (waived if admitted) Deductible & 20% Co-insurance	Same as In-network benefits
☐ Non-emergency use of the emergency room	No Cost	Not a covered service	Not a covered service

**Inpatient Hospital Services**

☐ Daily room, board and general nursing care at semi-private room rate; ICU/CCU; other medically necessary hospital charges such as diagnostic x-ray and lab services; newborn nursery care	No Cost	Member pays \$400 Co-pay per admittance, then deductible & 20% Co-insurance	Member pays \$1200 Co-pay per admittance then deductible & 50% Co-insurance
☐ Physician services (anesthesiologist, radiologist, pathologist)	No Cost	Member pays deductible then 20%	Member pays deductible then 50%

**Outpatient Services**

☐ Surgery facility / hospital charges	No Cost	Member pays deductible then 20%	Member pays deductible then 50%
☐ Diagnostic X-ray and lab services	No Cost	Member pays deductible then 20%	Member pays deductible then 50%
☐ Physician services (surgeon, anesthesiologist, radiologist, pathologist)	No Cost	Member pays deductible then 20%	Member pays deductible then 50%

Covered Services		In-Network Benefit	Out-of-Network Benefit
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**Therapy Services**

**Calendar year maximums are combined between in-network and out-of-network**

☐ Speech therapy (20 visit limit annually)	No Cost	Member pays deductible then 20%	Member pays deductible then 50%
☐ Physical, occupational therapy, chiropractic care and services of athletic trainers (20 visit limit <u>combined</u> annually)	No Cost	Member pays deductible then 20%	Member pays deductible then 50%
☐ Pulmonary/Cardiac therapy	No Cost	Member pays deductible then 20%	Member pays deductible then 50%
☐ Radiation therapy and chemotherapy	No Cost	Member pays deductible then 20%	Member pays deductible then 50%

**Mental Health / Substance Abuse**

**Services must be authorized by calling 1-888-741-2673**

☐ Inpatient (facility and physician fee)	No Cost	Member pays deductible then 20%	Member pays deductible then 50%
☐ Inpatient Substance Abuse Detoxification (facility and physician fee)	No Cost	Member pays deductible then 20%	Member pays deductible then 50%
☐ Partial Hospitalization Program (facility and physician fee)	No Cost	Member pays deductible then 20%	Member pays deductible then 50%
☐ Intensive Outpatient Program (facility and physician fee)	No Cost	Member pays deductible then 20%	Member pays deductible then 50%
☐ Professional Outpatient Services	No Cost	Member pays deductible then 20%	Member pays deductible then 50%
☐ Mental Health OFFICE VISITS	No Cost	\$25 Co-pay (waiving deductible)	Member pays deductible then 50%

**Other Services**

**Calendar year maximums are combined between in-network and out-of-network**

☐ Urgent Care Center	No Cost	\$75 Co-pay	\$75 copayment Member pays deductible then 50%
☐ Skilled Nursing Facility (30-day calendar year maximum)	No Cost	Member pays deductible then 20%	Member pays deductible then 50%
☐ Home Health Care (120-day calendar year maximum)	No Cost	Member pays deductible then 20%	Member pays deductible then 50%
☐ Hospice Care	No Cost	Member pays deductible then 20%	Member pays deductible then 50%
☐ Ambulance (Ground)	NA	Member pays deductible then 20%	Member pays deductible then 50%
☐ Infusion Services	20%	Member pays deductible then 20%	Member pays deductible then 50%
☐ Durable Medical Equipment (DME)	20%	Member pays deductible then 20%	Member pays deductible then 50%
☐ Orthotics		Member pays deductible then 20%	Member pays deductible then 50%
☐ Prosthetics	20%	Member pays deductible then 20%	Member pays deductible then 50%

PRESCRIPTION CO-PAYS (The greater of the flat-dollar co-payment or coinsurance)		RETAIL PHARMACY (30-day supply only)	MAIL ORDER (60, 90-day supply)
Generic	N/A	\$10	\$25
Preferred	N/A	\$30 or 20% (\$100 Max)	\$60 or 20% (\$200 Max)
Non-Preferred	N/A	\$60 or 50% (\$300 Max)	\$120 or 50% (\$600 Max)
Specialty Drug Co-Pay	N/A	20% (\$1,000 Max)	NA
<p>This Schedule of Benefits is part of your Certificate of Insurance but does not replace it. Many words are defined elsewhere in the Certificate, and other limitations or exclusions may be listed in other sections of your Certificate. Reading this Schedule by itself could give you an inaccurate impression of the terms of your coverage. This Schedule must be read with the rest of your Certificate.</p> <p><input type="checkbox"/> Prior authorization may be required for specific services.</p> <p><input type="checkbox"/> Payment to Out-of-Network providers is based on the Out-of-Network Rate (ONR).</p> <p><input type="checkbox"/> Preventative Services must qualify as such as specified in your contract and the PPACA in order to be exempt from applicable deductibles.</p> <p><input type="checkbox"/> <u>Please note that Ancillary Providers (Anesthesiologist, Radiologist, Pathologist, etc.) not employed by MLMC are paid under the In-Network column subject to the deductible and coinsurance.</u></p>			

Updated 01/01/2025