



Outline of Coverage

HISway

Link \$3000

Benefit Plan Year	January 1, 2024 – December 31, 2024	
Benefit Accrual Period	Calendar Year	
Maximum Lifetime Benefit	In-network	Out-of-network
Individual (per member)	Unlimited	Unlimited
Deductible	In-network	Out-of-network
Individual (per member)	\$3,000	\$6,000
Family (per family)	\$6,000	\$12,000
Out-of-Pocket Limit Per	In-network	Out-of-network
Individual (per member)	\$5,500	\$8,000
Family (per family)	\$11,000	\$16,000
Coinsurance	In-network	Out-of-network
	20%	40%

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.

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Covered Benefit	YOUR COST IN-NETWORK	YOUR COST OUT-OF-NETWORK
Preventive Care		
Preventive/Wellness	No Charge	40% After Deductible

Professional Services*		
Primary care office visit	\$30 Copay	40% After Deductible
Specialist office visit	\$50 Copay	40% After Deductible
Therapy office visit - PT, OT, ST <i>(30 visits per year combined)</i>	\$60 Copay	40% After Deductible
Doctor on Demand	No Charge	Not Applicable
Surgeon	20% After Deductible	40% After Deductible
Anesthesiologist	20% After Deductible	40% After Deductible
Outpatient habilitation services <i>(20 visits per year combined)</i>	20% After Deductible	40% After Deductible
Outpatient rehabilitation services <i>(20 visits per year combined)</i>	20% After Deductible	40% After Deductible
Chiropractic Services <i>(20 visits per year)</i>	\$50 Copay	40% After Deductible
Hospital/Facility Services*		
Inpatient room and board	20% After Deductible	40% After Deductible
Inpatient habilitation services	20% After Deductible	40% After Deductible
Inpatient rehabilitation services	20% After Deductible	40% After Deductible
Skilled nursing facility care <i>(30 days per year)</i>	20% After Deductible	40% After Deductible
Outpatient surgery/services	20% After Deductible	40% After Deductible
Diagnostic and therapeutic radiology/laboratory and dialysis	20% After Deductible	40% After Deductible
Center of Excellence with prior approval by the Co-op	20% After Deductible	40% After Deductible
Urgent and Emergency Services		
Urgent care center	\$50 Copay	40% After Deductible

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Doctor on Demand	No Charge	N/A
Emergency room	\$100 + 20% After Deductible	\$100 + 20% After Deductible
Ambulance; ground and air	20% After Deductible	20% After Deductible
Prescription Drug Benefit*	<i>If you choose a higher Tier drug when a lower Tier drug is available, you may be subject to additional member responsibility.</i>	
\$0 Out of Pocket Prescriptions (Tier 5 online search)	No Charge	N/A
Retail Pharmacy Prescriptions - (30-day supply)		
Tier 1-Preferred Generic Drug	\$5 Copay	\$5 Copay
Tier 2-Preferred Brand and Non-Preferred Generic Drugs	\$15 Copay	\$15 Copay
Tier 3-Non-Preferred Brand Drugs	\$50 Copay	\$50 Copay
Tier 4-Non-Preferred Brand Drugs (Specialty Drugs)	20% After Deductible	N/A
Mail Order Maintenance - (90-day supply)		
Tier 1-Preferred Generic Drug	\$10 Copay	N/A
Tier 2-Preferred Brand and Non-Preferred Generic Drugs	\$30 Copay	N/A
Tier 3-Non-Preferred Brand Drugs	\$100 Copay	N/A
Mental Health, Autism Spectrum Disorder and Substance Use Disorder Services*		
Office visits	\$0 first visit, then \$30 Copay	40% After Deductible
Inpatient care	20% After Deductible	40% After Deductible
Outpatient care	20% After Deductible	40% After Deductible
Doctor on Demand	No Charge	Not Applicable
Residential programs	20% After Deductible	40% After Deductible
Other Covered Services*		
Durable medical equipment	20% After Deductible	40% After Deductible
Home health	20% After Deductible	40% After Deductible
Prosthetics	20% After Deductible	40% After Deductible
Transplants	20% After Deductible	40% After Deductible
Hearing Device (For dependents under age 19)	No Charge	No Charge

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Pediatric Vision Care Services		<i>This Vision Care Benefit only applies to Covered Dependents under age 19.</i>
Vision examination <i>(One per year)</i>	No Charge	25% After Deductible
Vision care materials <i>(See policy for limitations)</i>	No Charge	25% After Deductible
Vision Exam Reimbursement		Reimbursement Maximum
Vision examination <i>(One per year)</i>		\$60
Dental Exam Reimbursement		Reimbursement Maximum
Dental exam/cleaning <i>(One per year)</i>		\$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.

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