

# 2023 Medical plan benefit summary



This summary is for quoting purposes only

## Endeavor Select HDHP\_ \$2500\_ \$5000\_ 20%\_ AGG

|  | In-network you pay | Out-of-network you pay <sup>1</sup> |
|--|--------------------|-------------------------------------|
| <b>Employee only</b> <i>Applies if employee is enrolling with no other family members.</i> |                    |                                     |
| Calendar year costs  |                    |                                     |
| Deductible per member  | \$2,500            | \$5,000                             |
| Out-of-pocket max including deductible   | \$5,000            | \$45,000                            |
| <b>Employee and one or more dependent(s)</b>   |                    |                                     |
| Calendar year costs  |                    |                                     |
| Deductible per family (Aggregate) <sup>2</sup>   | \$5,000            | \$10,000                            |
| Out-of-pocket max including deductible per member (Embedded) <sup>3</sup>                  | \$5,000            | \$45,000                            |
| Out-of-pocket max including deductible per family  | \$10,000           | \$90,000                            |
| <b>Care and services</b>   |                    |                                     |
| ACA preventive care visit  | \$0*               | 50%                                 |
| PCP office visit   | 20%                | 50%                                 |
| CirrusMD virtual visit   | 0%                 | N/A                                 |
| Other virtual visit  | 20%                | 50%                                 |
| Specialist visit   | 20%                | 50%                                 |
| Urgent care visit  | 20%                | 50%                                 |
| Outpatient mental health/substance use disorder visit                                      | 20%                | 50%                                 |
| Acupuncture care, spinal manipulations (24 visits per year)                                | 20%                | 50%                                 |
| <b>Maternity care</b>  |                    |                                     |
| Practitioner services  | 20%                | 50%                                 |
| Hospital stay  | 20%                | 50%                                 |
| <b>Hospital inpatient / outpatient services</b>  |                    |                                     |
| Inpatient Care   | 20%                | 50%                                 |
| Skilled nursing facility care (30 days per year)   | 20%                | 50%                                 |
| Outpatient hospital / facility   | 20%                | 50%                                 |
| Outpatient diagnostic x-ray and lab  | 20%                | 50%                                 |
| Advanced imaging (MRI, CT, CAT, PET scans)   | 20%                | 50%                                 |
| Emergency room: facility   |                    | 20%                                 |
| Emergency room: physician, lab and other services  |                    | 20%                                 |
| <b>Other covered services</b>  |                    |                                     |
| Outpatient rehabilitation (30 sessions per year)   | 20%                | 50%                                 |
| Therapeutic injections   | 20%                | 50%                                 |
| Durable medical equipment (DME)/ prosthetics   | 20%                | 50%                                 |
| Massage Therapy (24 visits per year)   | 20%                | 50%                                 |
| Ambulance service (6 trips per year)   |                    | 20%                                 |
| Home health, hospice, and respite care (limits may apply)                                  | 20%                | 50%                                 |
| <b>Prescription Medication<sup>4</sup></b>   |                    | 20%                                 |

\* Deductible waived

<sup>1</sup> Out-of-network coverage coinsurance is based on the maximum plan allowance for these services.

<sup>2</sup> If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.

<sup>3</sup> If you have family members on the policy, the individual out-of-pocket max applies for each member only until the family out-of-pocket max is met.

<sup>4</sup> \$0 copay for Value Medications\*

Every licensed professional provider (non-facility) in Alaska is covered at the in-network level. Services outside of Alaska are subject to the PPO network, in and out of network benefits for providers and facilities applies.

*This is a summary of the medical benefits and is not a contract. If there is any discrepancy between the information in this summary and the contract, it is the contract that will control.*

*This document is provided for informational purposes only, and is intended for licensed and appointed producers of Moda Health. It is not considered a Summary of Benefits and Coverage (SBC), and should not be distributed to employers or their employees as a replacement for the SBC.*