## 2024 Medical plan benefit summary



Deductible per family  Out-of-pocket max per person  Out-of-pocket max per family  Care & services  Preventive care visit  Primary care provider (PCP) office visit  Specialist office visit  Virtual care visit - CirrusMD  Other providers  Outpatient diagnostic X-ray & lab  Emergency room visit  Ambulance  Mental health/ substance use disorder office visit  Other outpatient mental health/substance use disorder services  Physical, speech or occupational therapy and spinal manipulation visit  Embedded pediatric dental  Pediatric vision exam  Pediatric vision hardware  Prescription medications²  Value  Select  Seloct  Preferred  \$40  Non-Preferred  \$40  Seloct deductible  \$50  Seloct  \$40/visit  Selocy isit  Shorting is person  Splice is provided is provided is person  Splice is provided is p	Not Covered ANOT Covered Not Covered A0% after deductible
Deductible per person  Deductible per family  S11,800  Out-of-pocket max per person  S9,100  Out-of-pocket max per family  S18,200  Care & services  Preventive care visit  Specialist office visit  Specialist office visit  Virtual care visit  Outpetient diagnostic X-ray & lab  Cher groun visit  Ambulance  Ungatint/outpatient Care  Mental health/ substance use disorder office visit  Mental health/ Substance use disorder services  Physical, speech or occupational therapy and spinal manipulation visit  Embedded pediatric dental  Pediatric vision hardware  Prescription medications²  Value  \$20  Select  \$20  Preferred  \$40  Non-Preferred  \$80 after deductible	Not Covered And Covered Not Covered And Covered
Deductible per family Out-of-pocket max per person Out-of-pocket max per family S18,200  Care & services Preventive care visit Primary care provider (PCP) office visit Specialist office visit Virtual care visit Other providers Outpatient diagnostic X-ray & lab Emergency room visit Ambulance Mental health/ substance use disorder services Where outpatient mental health/substance use disorder services Physical, speech or occupational therapy and spinal manipulation visit Embedded pediatric dental Pediatric vision exam Pediatric vision exam Perferred Select Preferred Select S20 Preferred Non-Preferred Preferred Specialty S0/visit S1,200 Select S20 Select S20 Preferred S40 Solvisit S0/visit	Not Covered And Covered Not Covered And Covered
Out-of-pocket max per person Out-of-pocket max per family Care & services Preventive care visit Primary care provider (PCP) office visit Specialist office visit Virtual care visit Other providers Outpatient diagnostic X-ray & lab Emergency room visit Ambulance Ungatient/outpatient Care Mental health/ substance use disorder office visit Other outpatient mental health/substance use disorder services Physical, speech or occupational therapy and spinal manipulation visit Embedded pediatric dental Pediatric vision exam O% Prescription medications² Value Select Preferred \$40 Non-Preferred \$80 after deductible  \$40/visit Out overed \$40/visit Outpatient mental Application visit Outpatient dental Ow	Not Covered  N/A  Not Covered  Not Covered  And Covered  Not Covered  Not Covered  Not Covered
Cut-of-pocket max per family Care & services  Preventive care visit  Specialist office visit  Other providers  Specialist office visit  Other providers  Specialist of deductible  Announce  Announc	Not Covered  Not Covered  Not Covered  Not Covered  Not Covered  N/A  Not Covered  Not Covered  40% after deductible
Care & services  Preventive care visit  Primary care provider (PCP) office visit  Specialist office visit  Other providers  Specialist office visit  Other providers  Specialist office visit  Other providers  Specialist office visit  Other office visit  Specialist of visit  Specialist office visit  Specialist of visit  Speciali	Not Covered Not Covered Not Covered Not Covered N/A Not Covered Not Covered 40% after deductible
Preventive care visit  Primary care provider (PCP) office visit  Specialist office visit  Other providers  Specialist office visit  Other providers  Specialist office visit  Other providers  Specialist office visit  Other on visit  Specialist office visit  Specialist office visit  Other outpatient Care  Other outpatient mental  Specialist office visit  Other outpatient mental  Specialist office visit  Specialist office visit  Other outpatient mental  Specialist office visit  Analysist  Analysist  Specialist office visit  Specialist office v	Not Covered Not Covered Not Covered N/A Not Covered Not Covered 40% after deductible
Primary care provider (PCP) office visit  Specialist office visit¹  Specialist office visit of the providers of the provider of the pr	Not Covered Not Covered Not Covered N/A Not Covered Not Covered 40% after deductible
Specialist office visit¹  Urgent care visit  Urgent care visit  Other providers  Other providers  Outpatient diagnostic X-ray & lab  Outpatient deductible  Ambulance  Ambulance  And after deductible  Mental health/  Substance use disorder office visit  Other outpatient mental  Health/substance use disorder  Services  Only after deductible  Adovisit  Outpatient mental  Health/substance use disorder  Services  Only after deductible  Services  Se	Not Covered Not Covered N/A Not Covered Not Covered 40% after deductible
Urgent care visit \$60/visit  Virtual care visit - CirrusMD  Other providers  Other providers  Outpatient diagnostic X-ray & lab  Outpatient deductible  Ambulance  Ambulance  Ambulance  Mental health/ substance use disorder office visit  Other outpatient mental mealth/substance use disorder services  Outpatient deductible  Services  Outpatient deductible  Ou	Not Covered N/A Not Covered Not Covered 40% after deductible
Other providers Other providers Other providers Other providers Outpatient diagnostic X-ray & lab Outpatient deductible Outpatient deductible Outpatient Care Outpatient Care Outpatient mental Outpatie	N/A Not Covered Not Covered 40% after deductible
Other providers \$40/visit  Outpatient diagnostic X-ray & lab	Not Covered Not Covered 40% after deductible
Outpatient diagnostic X-ray & lab  Emergency room visit  Authorization diagnostic X-ray & lab  Emergency room visit  Authorization diagnostic X-ray & lab  Emergency room visit  Authorization diagnostic X-ray & lab  Authorization deductible  Authorization diagnostic X-ray & lab  Authorization deductible  Authorization diagnostic X-ray & lab  Authorization deductible  Authorization deductible  Authorization diagnostic X-ray & lab  Authorization deductible  Authorization deductible  Authorization diagnostic X-ray & lab  Authorization deductible  Authorization deductible  Authorization diagnostic X-ray & lab  Authorization deductible  Authori	Not Covered 40% after deductible
Emergency room visit  Aumbulance  Aumbulan	40% after deductible
Ambulance Inpatient/outpatient Care Inpatient/outpatient Gare Inpatient/outpatient Inpatient Inpatie	
Inpatient/outpatient Care  Mental health/ Substance use disorder office visit  Other outpatient mental health/substance use disorder Services  Physical, speech or occupational therapy and spinal manipulation visit  Embedded pediatric dental  Pediatric vision exam  Pediatric vision hardware  Prescription medications²  Value  Select  Preferred  Select  Solon-Preferred  \$80 after deductible  \$350 after deductible	40% after deductible
Wental health/ Substance use disorder office visit  Other outpatient mental Dealth/substance use disorder Describes	40% arter deductible
substance use disorder office visit Other outpatient mental lealth/substance use disorder ervices Othysical, speech or occupational therapy and spinal manipulation visit Imbedded pediatric dental Overed Overediatric vision exam Overediatric vision hardware Overescription medications Overescription medications Overediatric Overed Overescription medications Overescription	Not Covered
tealth/substance use disorder ervices  thysical, speech or eccupational therapy and spinal manipulation visit  the diatric vision exam  the diatric vision hardware  trescription medications <sup>2</sup> treferred  the diatric dental  the diatric vision hardware  the diatric vision hard	Not Covered
specupational therapy and spinal \$40/visit  Embedded pediatric dental Not Covered  Pediatric vision exam 0%  Pediatric vision hardware 0%  Prescription medications <sup>2</sup> Value \$20 Select \$20 Preferred \$40  Non-Preferred \$80 after deductible  Preferred Specialty \$350 after deductible	Not Covered
Embedded pediatric dental  Pediatric vision exam  Pediatric vision hardware  Prescription medications <sup>2</sup> Value  Select  Preferred  Select  Solutions  Solution  Solut	Not Covered
Pediatric vision hardware  Prescription medications <sup>2</sup> Value \$20  Select \$20  Preferred \$40  Non-Preferred \$80 after deductible  Preferred Specialty \$350 after deductible	Not Covered
Prescription medications <sup>2</sup> Value \$20  Select \$20  Preferred \$40  Non-Preferred \$80 after deductible  Preferred Specialty \$350 after deductible	Not Covered
Value \$20 Select \$20 Preferred \$40 Non-Preferred \$80 after deductible Preferred Specialty \$350 after deductible	Not Covered
Value \$20 Select \$20 Preferred \$40 Non-Preferred \$80 after deductible Preferred Specialty \$350 after deductible	
referred \$40  Ion-Preferred \$80 after deductible referred Specialty \$350 after deductible	\$20
referred \$40 Ion-Preferred \$80 after deductible referred Specialty \$350 after deductible	\$20
Non-Preferred \$80 after deductible Preferred Specialty \$350 after deductible	\$40
referred Specialty \$350 after deductible	\$80 after deductible
	Not Covered
	Not Covered
eatures	
Metallic level Silver	
exchange	
Provider network Moda Select	
First Health	
dervice area Hays, Travis, Williams	

<sup>1</sup> Hearing exam is subject to \$45/visit.

<sup>2</sup> Copay amounts are per 30-day supply. Insulin \$25 maximum cost share for a 30-day supply.

## Limitations

- Authorization by Moda Health is required for all medical and surgical admissions and some outpatient services and medications
- Biofeedback limited to 10 visits per lifetime for tension or migraine headaches or urinary incontinence
- Coordination of benefits when a member has more than one health plan, combined benefits for all plans is limited to the maximum plan allowance for all covered services.
   An expense paid under Medicare will have benefits reduced by the amount Medicare paid
- Hearing aids covered once every 3 years. Hearing tests covered once per year.
- Infusion therapy Some medications require use of preferred medication suppliers to be eligible for coverage
- Prescriptions If using a brand medication when a generic equivalent is available, the member will have to pay the nonpreferred cost sharing plus the difference in cost between the generic and brand medication. Prescriptions are limited to a 30-day supply for standard retail and most specialty pharmacy and 90 days for mail order and participating retail. Some medications require enrollment in programs with an exclusive pharmacy provider.
- Preventive care Cost sharing may apply to services not required under the Affordable Care Act
- Rehabilitation and habilitation benefits (physical, occupational, and speech therapy and spinal manipulation) covered up to 35 sessions per year. Limits apply separately to rehabilitation and habilitation services.
- Skilled nursing facility covered up to 25 days per year
- Transplants must be performed at the authorized transplant facilities to be eligible for coverage
- Vision exam and glasses or contacts covered once per year for members under age 19
- Vision exam covered once per year for members aged 19 and older

## **Exclusions**

- Abortion, except in the case of a medical emergency of a pregnant woman
- Acupuncture
- Care outside the United States, other than emergency care
- Charges above the maximum plan allowance
- Cosmetic services and supplies (exception for reconstructive surgery if medically necessary and not specifically excluded)
- Court-ordered services
- Custodial care
- Dental examinations and treatment except for accidental injury
- Experimental or investigational treatment
- Infertility (services or supplies for treatment of, including reversal of sterilization)
- Injury resulting from practicing for or participating in professional athletic events
- Instruction programs, except as provided under the outpatient diabetic instruction benefit
- Massage or massage therapy
- Naturopathic supplies, including herbal, naturopathic or homeopathic medicines, substances or devices and any other nonprescription supplements
- Obesity (all services and supplies except those required under the Affordable Care Act)
- Optional services or supplies, including those for comfort, convenience, environmental control or education, and treatment not medically necessary
- Orthognathic surgery except when medically necessary to repair an accidental injury or for treatment of cancer
- Services or supplies available under any city, county, state or federal law and a member has no obligation to pay, except Medicaid
- Services provided by the patient
- Services provided by a member of the patient's immediate family
- Temporomandibular Joint Syndrome (TMJ), any non-surgical or non-diagnostic services or supplies provided for the treatment of the temporomandibular joint and all adjacent or related muscles and nerves
- Vision surgery to alter the refractive character of the eye

This document is provided for informational purposes only, and is intended as a quick reference of Moda Health plan benefits. It is not considered a Summary of Benefits and Coverage (SBC), and should not be regarded as a replacement for the SBC. For cost and additional details of the coverage, including exclusions, any reduction or limitations and the terms under which the policy may be continued in force, contact your producer or Moda Health.

This is a summary of the health plan 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.