

# 2026 Medical plan benefit summary

## ● Moda Select Texas Silver 5000 Direct (\$0 Virtual Urgent Care through CirrusMD)

|                                                                              | In network you pay                                                                        | Out-of-network you pay |
|------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|------------------------|
| Calendar year costs                                                          |                                                                                           |                        |
| Deductible per person                                                        | \$5,000                                                                                   | Not covered            |
| Deductible per family                                                        | \$10,000                                                                                  | Not covered            |
| Out-of-pocket max per person                                                 | \$7,750                                                                                   | Not covered            |
| Out-of-pocket max per family                                                 | \$15,500                                                                                  | Not covered            |
| Care & services                                                              |                                                                                           |                        |
| Preventive care visit                                                        | \$0 per visit                                                                             | Not covered            |
| Primary care provider (PCP) office visit                                     | \$40 per visit                                                                            | Not covered            |
| Specialist office visit<br><i>Hearing exam is subject to \$45/visit.</i>     | \$70 per visit                                                                            | Not covered            |
| Urgent care visit                                                            | \$70 per visit                                                                            | Not covered            |
| Virtual care visit - CirrusMD                                                | \$0 per visit                                                                             | Not covered            |
| Other providers                                                              | \$30 per visit                                                                            | Not covered            |
| Outpatient diagnostic X-ray & lab                                            | 35% after deductible                                                                      | Not covered            |
| Emergency room visit                                                         | 50% after deductible                                                                      | 50% after deductible   |
| Ambulance                                                                    | 35% after deductible                                                                      | 35% after deductible   |
| Inpatient/outpatient Care                                                    | 35% after deductible                                                                      | Not covered            |
| Mental health/<br>substance use disorder office visit                        | \$40 per visit                                                                            | Not covered            |
| Physical, speech or<br>occupational therapy and spinal<br>manipulation visit | \$70 per visit                                                                            | Not covered            |
| Dental services for under age 19                                             | Not covered                                                                               | Not covered            |
| Vision exam for under age 19                                                 | \$0 per visit                                                                             | Not covered            |
| Vision hardware for under age 19                                             | 0%                                                                                        | Not covered            |
| Adult vision exam                                                            | Not covered                                                                               | Not covered            |
| Prescription medications                                                     | Copay amounts are per 30-day supply. Insulin \$25 maximum cost share for a 30-day supply. |                        |
| Value                                                                        | \$2                                                                                       | \$2                    |
| Select                                                                       | \$20                                                                                      | \$20                   |
| Preferred                                                                    | 40%                                                                                       | 40%                    |
| Non-Preferred                                                                | 50% after deductible                                                                      | 50% after deductible   |
| Preferred Specialty                                                          | 40%                                                                                       | Not covered            |
| Non-Preferred Specialty                                                      | 50% after deductible                                                                      | Not covered            |
| Features                                                                     |                                                                                           |                        |
| Metallic level                                                               | ● Silver                                                                                  |                        |
| Exchange                                                                     | Off                                                                                       |                        |
| Medicare Part D creditable                                                   | Creditable                                                                                |                        |
| Provider network                                                             | Moda Select                                                                               |                        |
| Travel network                                                               | First Health                                                                              |                        |
| Service area                                                                 | Hays, Travis, Williamson                                                                  |                        |

Limitations and exclusions apply. See the Summary of Benefits and Coverage (SBC) and the member handbook for the requirements, limitations and exclusions of the Plan. This document is provided for informational purposes only, and is intended for licensed and appointed producers of Moda Health. It is not an SBC and should not be regarded as a replacement for the SBC. If there is any discrepancy between the information in this summary and the contract, it is the contract that will control.