

Healthy Foundations 2020/2021 Medical Plan Benefit Summary

Medical Plan Feature	CityCore Medical Plan		CityNet Medical Plan	
	In-Network Plan Pays	Out-of-Network Plan Pays	In-Network Plan Pays	Out-of-Network Plan Pays
Network	The CityCore Plan's network is the Connexus Network. During the year you can go in-network or out-of-network as you choose. When you go in-network, you will have fewer out-of-pocket expenses.		The CityNet Plan's network is the Connexus Network. During the year you can go in-network or out-of-network as you choose. When you go in-network, you will have fewer out-of-pocket expenses.	
Maximum Plan Allowance (MPA)	After the deductible, plan pays benefits based on negotiated rates.	After the deductible, plan pays benefits based on MPA limits.	After the deductible, plan pays benefits based on negotiated rates.	After the deductible, plan pays benefits based on MPA limits.
Plan Year Deductible CityCore in-network deductible applies to services as indicated throughout this chart. Out of network excludes in-network expenses. Charges over MPA not applied to deductible.	\$250/person; \$750/family maximum	\$650/person; \$1,950/family maximum	\$150/person; \$450/family maximum	\$450/person; \$1,350/family maximum
Plan Year Out-of-Pocket Maximum (charges over MPA do not apply to annual maximum)	\$1,800/person; \$5,400/family maximum (excludes out-of-network expenses)	\$10,500/person; \$31,500/family maximum (excludes in-network expenses)	\$1,000/person; \$2,500/family maximum (excludes out-of-network expenses)	\$3,600/person; \$9,000/family maximum (excludes in-network expenses)
Lifetime Maximum Benefits	No lifetime maximum benefit limit		No lifetime maximum benefit limit	
Prior Authorization	Required for hospitalization. Other services requiring prior authorization are listed on page 94 of the handbook.		Required for hospitalization. Other services requiring prior authorization are listed on page 87 of the handbook.	

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<p>Wellness Routine Physical Exams & Immunizations (except for travel-related immunizations)</p> <p>Non-routine lab work and/or tests and other medically necessary exams are <i>not</i> covered at 100%, but will be covered at regular benefit levels.</p> <p>Services as required under the Affordable Care Act</p>	<p>100% No deductible</p> <p>Your Responsibilities:</p> <ul style="list-style-type: none"> ○ When making an appt., double check when your last routine exam occurred to ensure you are eligible for the service at the 100% benefit level. ○ Seek services through an in-network provider. ○ Ensure your provider uses an in-network lab. <p>Read your Moda Health explanation of benefits to confirm billing & payment to your provider. If there is an error contact Moda Health & your provider to ensure the correct payment.</p>	<p>60% of MPA after deductible</p>	<p>100% No deductible</p> <p>Your Responsibilities:</p> <ul style="list-style-type: none"> ○ When making an appt., double check when your last routine exam occurred to ensure you are eligible for the service at the 100% benefit level. ○ Seek services through an in-network provider. ○ Ensure your provider uses an in-network lab. <p>Read your Moda Health explanation of benefits to confirm billing & payment to your provider. If there is an error contact Moda Health & your provider to ensure the correct payment.</p>	<p>60% of MPA after deductible</p>

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	<p>Routine physical exam maximum: Infant 6 exams in first 12 months Ages 1 to 4 7 exams Ages 5 and older 1 exam per 12 months Routine vision screening for age 3 to 5 Newborn hearing screening</p> <p>Cancer Screenings:</p> <p>Breast Cancer-Mammogram maximum: Ages 35-39 1 Ages 40+ 1 per 12 months (365 days) At any age when high risk and deemed necessary by physician</p> <p>Cervical Cancer-Pap Smear maximum: 1 per 12 months or at any time when high risk and deemed necessary by physician. NOTE: Women should begin screenings within 3 years of sexual activity or age 21 whichever is earlier.</p> <p>Prostate Cancer-PSA maximum: 1 per 12 months (365 days)</p> <p>Colorectal cancer screening maximums(including hospital, sedation and related tissue pathology charges—pre or post op office visits are covered at regular copays): Age 50 + 1 sigmoidoscopy every 5 years or 1 colonoscopy every 10 years More frequent sigmoidoscopy or colonoscopy procedures will be covered when deemed necessary by a physician because of high risk or family history. Age 50 + 1 fecal occult blood test per 12 mos.</p>		<p>Routine physical exam maximum: Infant 6 exams in first 12 months Ages 1 to 4 7 exams Ages 5 and older 1 exam per 12 months Routine vision screening for age 3 to 5 Newborn hearing screening</p> <p>Cancer Screenings:</p> <p>Breast Cancer-Mammogram maximum: Ages 35-39 1 Ages 40+ 1 per 12 months (365 days) At any age when high risk and deemed necessary by physician</p> <p>Cervical Cancer-Pap Smear maximum: 1 per 12 months or at any time when high risk and deemed necessary by physician. NOTE: Women should begin screenings within 3 years of sexual activity or age 21 whichever is earlier.</p> <p>Prostate Cancer-PSA maximum: 1 per 12 months (365 days)</p> <p>Colorectal cancer screening maximums(including hospital, sedation and related tissue pathology charges—pre or post op office visits are covered at regular copays): Age 50 + 1 sigmoidoscopy every 5 years or 1 colonoscopy every 10 years More frequent sigmoidoscopy or colonoscopy procedures will be covered when deemed necessary by a physician because of high risk or family history. Age 50 + 1 fecal occult blood test per 12 mos.</p>	
<p>Office Care Office visits, lab work, allergy shots; and other medically necessary exams.</p>	<p>100% no deductible. (from \$20 copay, specialist: \$35 copay)</p>	<p>60% of MPA after deductible.</p>	<p>100% no deductible. (from 80% after deductible)</p>	<p>60% of MPA after deductible.</p>
<p>Pregnancy – Prenatal visits and physician delivery charges</p>	<p>\$250 copay for physician services and lab work, plus 20% of hospital delivery services up to plan year out of pocket maximum after deductible.</p>	<p>60% of MPA after deductible.</p>	<p>20% up to plan year out-of-pocket maximum after deductible.</p>	<p>60% of MPA after deductible.</p>

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Diagnostic x-rays, MRIs, CT scans, ultrasound and other radiology services.	100% no deductible. <i>(from \$25 copay for diagnostic X-rays and \$75 copay for advanced imaging)</i>	60% of MPA after deductible.	100% no deductible. <i>(from 80% after deductible)</i>	60% of MPA after deductible.
Inpatient/Outpatient Hospital , including semi-private room and board; in-hospital diagnostic x-rays and lab work; surgery, anesthesia and miscellaneous services.	80% after deductible – inpatient hospital 100% no deductible – outpatient hospital <i>(Prior authorization may be required).</i>	60% of MPA after deductible.	80% after deductible – inpatient hospital 100% no deductible – outpatient hospital <i>(Prior authorization may be required).</i>	60% of MPA after deductible.
Emergency Room (copay waived if admitted as inpatient following emergency)	80% after \$200 copay (not subject to deductible)	80% of MPA after \$200 copay (not subject to deductible).	80% after \$50 copay (not subject to deductible)	80% of MPA after \$50 copay (not subject to deductible).
Urgent Care	100% no deductible. <i>(from \$35 copay for in-office visits, \$10 copay for OHSU virtual visits)</i>	60% of MPA, not subject to deductible.	100% no deductible. <i>(from 80% after deductible)</i>	60% of MPA, not subject to deductible.
Ambulance	80% of MPA; no deductible		80% of MPA; no deductible	
Alternative Care Providers (chiropractic, acupuncture, and naturopathic providers) The Connexus network provides in-network alternative care services for the CityCore plan.	100% no deductible. <i>(from \$20 copay)</i>	60% of MPA after deductible.	100% no deductible. <i>(from 80% after deductible)</i>	60% of MPA after deductible.
	28 visit annual maximum for spinal manipulation.		35 visit annual maximum for spinal manipulation.	
Gastric Restrictive Procedures (with or without gastric bypass or the revision of the same).	80% after deductible.	60% of MPA after deductible.	Not covered.	Not covered.
Nutritional Counseling & Hospital Based Weight Reduction Programs	100% no deductible, no visit limit. <i>(from 80% no deductible, 4 visit max. per plan year)</i>	100% no deductible, no visit limit. <i>(from 80% after deductible, 4 visit max. per plan year)</i>	100% no deductible, no visit limit. <i>(from 80% no deductible, no visit limit)</i>	100% no deductible, no visit limit. <i>(from 60% up to MPA after deductible, no visit limit)</i>
Physical Therapy	100% no deductible. <i>(from 80% after deductible)</i>	60% of MPA after deductible.	100% no deductible. <i>(from 80% after deductible)</i>	60% of MPA after deductible.
Skilled Nursing Facility	80% after deductible (30 day plan year maximum).	60% of MPA after deductible (30 day plan year maximum).	80% after deductible (30 day plan year maximum).	60% of MPA after deductible (30 day plan year maximum).
Rehabilitation/Habilitation Services , including occupational therapy and speech therapy	100% no deductible. <i>(from 80% after deductible)</i>	60% of MPA after deductible.	100% no deductible. <i>(from 80% after deductible)</i>	60% of MPA after deductible.
Durable Medical Equipment	100% no deductible. <i>(from 80% after deductible)</i>	60% of MPA after deductible.	100% no deductible. <i>(from 80% after deductible)</i>	60% of MPA after deductible.

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Medical Supplies	100% no deductible. <i>(from 80% after deductible)</i>	60% of MPA after deductible.	100% no deductible. <i>(from 80% after deductible)</i>	60% of MPA after deductible.
Home Healthcare	100% no deductible. <i>(Prior authorization may be required)</i>	60% of MPA after deductible.	100% no deductible. <i>(Prior authorization may be required)</i>	60% of MPA after deductible.
	60-visit plan year maximum		60-visit plan year maximum	
Hospice	100% no deductible. <i>(from 80% after deductible)</i>	60% of MPA after deductible.	100% no deductible. <i>(from 80% after deductible)</i>	60% of MPA after deductible.
Refractive Eye Surgery	Not covered.	Not covered.	Not covered.	Not covered.
Hearing Aids For members under age 26	80% up to plan year maximum (no deductible) every 48 months.	60% of MPA no deductible, up to a maximum of \$4,410 every 48 months.	80% up to plan year maximum (no deductible) every 48 months.	60% of MPA no deductible, up to a maximum of \$4,410 every 48 months.
For adults age 26 and older	60% of MPA no deductible, up to \$1,200 per ear; new hearing aid covered once every 36 months if medically necessary.		60% of MPA no deductible, up to \$1,200 per ear; new hearing aid covered once every 36 months if medically necessary.	
TMJ Treatment	Non-surgical benefit subject to deductible then paid at 80%. 2 nd surgical appliance subject to prior authorization. Maximum lifetime benefit of \$3000.	Non-surgical benefit subject to deductible then paid at 60%. 2 nd surgical appliance subject to prior authorization. Maximum lifetime benefit of \$3000.	Non-surgical benefit subject to deductible then paid at 80%. 2 nd surgical appliance subject to prior authorization. Maximum lifetime benefit of \$3000.	Non-surgical benefit subject to deductible then paid at 60%. 2 nd surgical appliance subject to prior authorization. Maximum lifetime benefit of \$3000.
Behavioral Health Mental Health Treatment	100% no deductible for outpatient services.	60% of MPA after deductible.	100% no deductible for outpatient office visits.	60% of MPA after deductible.
Prior authorization is required for all in-patient and residential treatment programs	100% no deductible for inpatient and residential treatment programs. <i>(from 100% after deductible for inpt/res programs; no charge for outpatient office visits)</i>		100% no deductible for inpatient and residential treatment programs. <i>(from 80% after deductible for inpt/res programs; no charge for outpatient office visits)</i>	

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Chemical Dependency Treatment Prior authorization is required for all in-patient and residential treatment programs	100% no deductible for outpatient office visits. 100% no deductible for inpatient and residential treatment programs. <i>(from 100% for outpt office visit; 100% after deductible for inpt/res. programs)</i>	60% of MPA after deductible.	100% no deductible for outpatient office visits. 100% no deductible for inpatient and residential treatment programs. <i>(from 80% after deductible)</i>	60% of MPA after deductible.
Sterilization, Contraceptive Implants (e.g., IUD and Norplant)	100%, no deductible	60% of MPA after deductible.	100%, no deductible	60% of MPA after deductible.
Sleep Apnea (including sleep studies)	100% no deductible; prior authorization required.	60% of MPA after deductible, prior authorization required.	100% no deductible; prior authorization required.	60% of MPA after deductible, prior authorization required.
Infertility Treatment	Not covered.	Not covered.	Not covered.	Not covered.
Applied Behavioral Analysis	80% after deductible. Single payer agreement required.	60% of MPA after deductible. Single payer agreement required.	80% after deductible. Single payer agreement required.	60% of MPA after deductible. Single payer agreement required.
Transgender	80% after deductible.	60% of MPA after deductible.	80% after deductible.	60% of MPA after deductible.
Prescription Medications Express Scripts Retail and Mail-Order Network retail pharmacy (up to 30-day supply, or a 90-day supply of maintenance meds) Mail order pharmacy (up to 90-day supply)	Deductible does not apply. Please refer to the member handbook for limitations and exclusions that may apply. –100% of generic drug cost <i>(from 90% and \$25 max copay)</i> –100% of preferred brand name drug cost. For statins and proton pump inhibitors (PPI), member to pay difference between cost of brand name & generic. <i>(from 80% and \$50 max copay)</i> –100% of non-preferred drug cost <i>(from 70% and \$75 max copay)</i> Same as in-network retail pharmacy benefit levels shown above Go online at www.express-scripts.com or call 855-889-7760 (CityCore)/800-818-9289 (CityNet) to compare pricing and pharmacy availability.	Deductible does not apply. Please refer to the member handbook for limitations and exclusions that may apply. –100% of generic drug cost <i>(from 90% and \$50 max copay)</i> –100% of preferred brand name drug cost. For statins and proton pump inhibitors (PPI), member to pay difference between cost of brand name & generic. <i>(from 80% and \$50 max copay)</i> –100% of non-preferred drug cost <i>(from 70% and \$50 max copay)</i> Same as in-network retail pharmacy benefit levels shown above		

*Benefits subject to change upon annual review. Vision and dental services are not part of the Healthy Foundations enhanced benefits. Items highlighted in yellow reflect changes in coverage for services through an in-network provider on the Healthy Foundations medical benefit plan. For questions about your Flexible Spending Account, refer to <https://www.wageworks.com/employees/support-center/> or call 877-924-3967 for support.