Healthy Foundations 2025/2026 Medical Plan Benefit Summary

Medical Plan Feature	CityCore Medical Plan		CityNet Medical Plan	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Network	The CityCore Plan's network for members residing in OR and SW WA 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 for members residing in OR and SW WA 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) is the maximum amount the Plan will reimburse providers.	After the deductible, plan pays benefits based on negotiated rates.	After the deductible, plan pays benefits based on MPA.	After the deductible, plan pays benefits based on negotiated rates.	After the deductible, plan pays benefits based on MPA.
Plan Year Deductible - CityCore in-network deductible applies to services as indicated in this chart. - Out of network excludes in-network expenses and vice versa. - Charges over MPA not applied to deductible.	$250 / individual; $750 / family	$650 / individual; $1,950 / family	$150 / individual; $450 / family	$450 / individual; $1,350 / family
Plan Year Out-of-Pocket Maximum (charges over MPA do not apply to annual maximum)	$1,800 / individual; $5,400 / family	$10,500 / individual; $31,500 / family	$1,000 / individual; $2,500 / family	$3,600 / individual; $9,000 / family
Lifetime Maximum Benefits	See gastric restrictive procedures below. See TMJ treatment section below.		See gastric restrictive procedures below. See TMJ treatment section below.	
Prior Authorization	Required for hospitalization. Other services requiring prior authorization are listed on page **75** of the SPD. For a full list of services visit modahealth.com or contact Moda customer service.		Required for hospitalization. Other services requiring prior authorization are listed on page **89** of the SPD. For a full list of services visit modahealth.com or contact Moda customer service.	
Wellness Routine Physical Exams & Immunizations (except for travel-related immunizations) - Non-routine lab work and/or tests and other medically necessary exams are not covered at 100% but will be covered at regular benefit levels. - Services as required under the Affordable Care Act	No charge Your Responsibilities: ○ When making an appointment, 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. Read your Moda Health explanation of benefits to confirm billing & payment to your provider. If there is an error contact Moda & your provider to ensure the correct payment.	40% after deductible	No charge Your Responsibilities: ○ When making an appointment, 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. Read your Moda Health explanation of benefits to confirm billing & payment to your provider. If there is an error contact Moda & your provider to ensure the correct payment.	40% after deductible

Medical Plan Feature	CityCore Medical Plan		CityNet Medical Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Exam / Screening frequencies	***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 ***Cancer Screenings**:* ***Breast Cancer-Mammogram maximum**:* Ages 35-39 1 total for age range Ages 40+ 1 per 12 months (365 days) At any age when high risk and deemed necessary by physician ***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.* ***Prostate Cancer-PSA maximum**:* 1 per 12 months (365 days) Covered earlier or more often if provider recommended ***Colorectal Cancer screenings*** No age or frequency limitations for preventive colorectal cancer screenings. See page **53** of SPD for full details. - sigmoidoscopy or colonoscopy including polyp removal - fecal occult blood test - double contrast barium One follow-up colonoscopy after positive screening is covered under the preventive benefit.		***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 ***Cancer Screenings**:* ***Breast Cancer-Mammogram maximum**:* Ages 35-39 1 total for age range Ages 40+ 1 per 12 months (365 days) At any age when high risk and deemed necessary by physician ***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.* ***Prostate Cancer-PSA maximum**:* 1 per 12 months (365 days) Covered earlier or more often if provider recommended ***Colorectal Cancer screenings*** No age or frequency limitations for preventive colorectal cancer screenings. See page **45** of SPD for full details. - sigmoidoscopy or colonoscopy including polyp removal - fecal occult blood test - double contrast barium One follow-up colonoscopy after positive screening is covered under the preventive benefit.	

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Primary Care Visits Office visits, lab work, allergy shots; and other medically necessary exams.	No charge	40% after deductible	No charge	40% after deductible
Specialist Visit	No charge	40% after deductible	No charge	40% after deductible
Virtual Visits with CirrusMD	No charge	N/A	No charge	N/A
Diagnostic test and Imaging Bloodwork, x-rays, MRIs, CT / PET scans, ultrasound and other radiology services.	No charge	40% after deductible	No charge	40% after deductible
Alternative Care Providers (chiropractic, acupuncture, and naturopathic providers)	No charge	40% after deductible	No charge	40% after deductible
	28 visit annual maximum for spinal manipulation		35 visit annual maximum for spinal manipulation	
Urgent Care	No charge	40% not subject to deductible	No charge	40% not subject to deductible
Ambulance	20% not subject to deductible	20% not subject to deductible	20% not subject to deductible	20% not subject to deductible
Emergency Room (copay waived if admitted as inpatient following emergency)	$200 copay/visit, then 20% not subject to deductible	$200 copay/visit, then 20% not subject to deductible	$50 copay/visit, then 20% not subject to deductible	$50 copay/visit, then 20% not subject to deductible
Inpatient/Outpatient Hospital, including semi-private room and board; in-hospital diagnostic x-rays and lab work; surgery, anesthesia, and miscellaneous services. Prior authorization may be required	20% after deductible – inpatient hospital	40% after deductible	20% after deductible – inpatient hospital	40% after deductible
	No charge – outpatient hospital	40% after deductible	No charge – outpatient hospital	40% after deductible
Gastric Restrictive Procedures (with or without gastric bypass or the revision of the same).	20% after deductible	40% after deductible	20% after deductible	40% after deductible
	$15,000 lifetime maximum		$15,000 lifetime maximum	
Gender confirming services See Covered Services Details below.	Services subject to standard medical benefit	40% after deductible	Services subject to standard medical benefit	40% after deductible
Sterilization, Contraceptive Implants (e.g., IUD and Norplant)	No charge	40% after deductible	No charge	40% after deductible
Infertility Treatment See page 7 below for details.	Only the initial visit and initial diagnostics to determine infertility are covered.		Only the initial visit and initial diagnostics to determine infertility are covered.	
Home Healthcare Prior authorization may be required	No charge	40% after deductible	No charge	40% after deductible
	60 visit plan year maximum		60 visit plan year maximum	
Rehabilitation/Habilitation Services, (physical, occupational, speech therapy)	No charge	40% after deductible	No charge	40% after deductible

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Skilled Nursing Care	20% after deductible	40% after deductible	20% after deductible	40% after deductible
	30 day plan year maximum		30 day plan year maximum	
Medical Supplies	No charge	40% after deductible	No charge	40% after deductible
Durable Medical Equipment	No charge	40% after deductible	No charge	40% after deductible
Hospice	No charge	40% after deductible	No charge	40% after deductible
Pregnancy – office visits– Prenatal visits and physician delivery charges	$250 copay, not subject to deductible, for physician services and lab work, plus 20% of hospital delivery services up to plan year out of pocket maximum after deductible.	40% after deductible	20% up to plan year out-of-pocket maximum after deductible.	40% after deductible
Nutritional Counseling & Hospital Based Weight Reduction Programs	No charge, no visit limit	No charge up to MPA (maximum plan allowance), no visit limit	No charge, no visit limit	No charge up to MPA (maximum plan allowance), no visit limit
Behavioral Health **Mental Health Treatment** Prior authorization is required for all in-patient and residential treatment programs	No charge for outpatient services. No charge for inpatient and residential treatment programs.	40% after deductible	No charge for outpatient office visits. No charge for inpatient and residential treatment programs.	40% after deductible
Applied Behavioral Analysis ABA for autism spectrum disorder is covered. Services must be prior authorized.	No charge for office visits. Other services covered at 20% after deductible.	40% after deductible	No charge for office visits. Other services covered at 20% after deductible.	40% after deductible
Substance Use Treatment Prior authorization is required for all in-patient and residential treatment programs	No charge for outpatient office visits. No charge for inpatient and residential treatment programs.	40% after deductible	No charge for outpatient office visits. No charge for inpatient and residential treatment programs.	40% after deductible
Sleep Apnea (including sleep studies) Prior authorization required	No charge	40% after deductible	No charge	40% after deductible
Hearing Aids **For members under age 26**	20% not subject to deductible, every 36 months.	40% not subject to deductible, every 36 months.	20% after deductible, every 36 months.	40% after deductible, every 36 months.
For adults age 26 and older See Covered Services Details below.	20% not subject to deductible up to $1,200 per ear every 36 months.	40% not subject to deductible, up to $1,200 per ear every 36 months.	40% not subject to deductible up to $1,200 per ear every 36 months.	40% not subject to deductible, up to $1,200 per ear every 36 months.

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	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
TMJ Treatment	Non-surgical benefit subject to deductible then pay at 20%. 2nd surgical appliance subject to prior authorization. Maximum lifetime benefit of $3000.	Non-surgical benefit subject to deductible then pay at 40%. 2nd surgical appliance subject to prior authorization. Maximum lifetime benefit of $3000.	Non-surgical benefit subject to deductible then pay at 20%. 2nd surgical appliance subject to prior authorization. Maximum lifetime benefit of $3000.	Non-surgical benefit subject to deductible then pay at 40%. 2nd surgical appliance subject to prior authorization. Maximum lifetime benefit of $3000.
Refractive Eye Surgery	Not covered	Not covered	Not covered	Not covered
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. – No charge for generic drug cost – No charge for preferred brand name drug cost. – No charge for non-preferred drug cost Out-of-network drug cost 40% coinsurance Same as in-network retail pharmacy benefit levels shown above		Deductible does not apply. Please refer to the member handbook for limitations and exclusions that may apply. – No charge for generic drug cost – No charge for preferred brand name drug cost. – No charge for non-preferred drug cost Out-of-network drug cost 40% coinsurance 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.			

*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://navia.my.site.com/helpcenter/s/ or call 1-800-669-3539 for support.

Exclusions: See member handbook for details.

Covered Services Details:

Gender Confirming Services
Eligibility for gender confirmation surgery is based on World Professional Association for Transgender Health (WPATH), Standard of Care. Medically necessary services to alter a member's physical characteristics to that of a new gender, including single stage or multiple stage reconstruction of genitalia and new reconstruction of breast tissue to achieve the appearance of the new gender. Services require prior authorization.

Expenses for gender confirming treatment are covered when you meet the following conditions:

a. Procedures must be performed by a qualified professional provider
b. Prior authorization is required for surgical procedures
c. Treatment plan must meet medical necessity criteria

Covered services may include:

a. Mental health (see Behavioral Health Mental Health Treatment in the above table)
b. Hormone therapy (including puberty suppression therapy for adolescents)
c. Surgical procedures (see section 7.4.34):
    i. Breast/chest surgery
    ii. Gonadectomy (hysterectomy/oophorectomy or orchiectomy)
    iii. Reconstruction of the genitalia
    iv. Gender confirming facial surgery

Hearing Services
Cochlear implants are covered when medically necessary and prior authorized. Benefits include programming and reprogramming the implant, and repair or replacement parts when medically necessary and not covered by warranty.

To get the highest benefit level for hearing services, call the Hearing Services preferred vendor to choose an in-network audiologist and schedule a hearing exam. The audiologist will help you choose hearing aids from the selection available to our members by the hearing services vendor through an in-network hearing instrument provider. You can also use other in-network and out-of-network providers, but you may pay more.

Age 26 and older
These are covered once every 3 years to a dollar maximum per ear if you are age 26 and older:

a. Hearing tests, hearing aid checks and aided testing once per year
b. One hearing aid per hearing impaired ear
c. Ear molds
d. Initial batteries, cords and other necessary supplementary equipment
e. One box of replacement batteries per year for each hearing aid
f. Repairs, servicing, or alteration of the hearing aid equipment

The hearing aid must be prescribed, fitted and dispensed by a licensed audiologist or hearing aid specialist with the approval of a licensed physician.

Under age 26

Hearing tests, hearing aid checks and aided testing are covered twice per year if you are under age 4 and once per year if you are age 4 to 26.

We cover these items once every 3 years if you are under age 26:

a. One hearing aid per hearing impaired ear
b. Repairs, servicing or alteration of the hearing aid equipment
c. Bone conduction sound processors, if necessary for appropriate amplification and prior authorized (the surgery to install the implant is covered at the surgical benefit level)
d. Hearing assistive technology system, if necessary for appropriate amplification and prior authorized and you are under age 19

We also cover:

a. Ear molds and replacement ear molds 4 times per year if you are under age 8 and once per year if you are age 8 to 26
b. Initial batteries and one box of replacement batteries per year for each hearing aid

The hearing aid must be prescribed, fitted and supplied by an audiologist or hearing aid specialist and referred by a licensed physician. We may cover a new hearing aid sooner if your existing hearing aid cannot be changed to meet your needs and you are under age 19.

Infertility Services

Any services related to the treatment of infertility and/or the cause of infertility are excluded from coverage under the Plan. This includes artificial insemination procedures, including, But not limited to, in-vitro fertilization (IVF), Gamete Intrafallopian Transfer (GIFT), Zygote Intrafallopian Transplant (ZIFT), and Tubal Embryo Transplant (TET). *Only the initial visit and initial diagnostics to determine infertility are covered. Standard office visit, x-ray, and lab cost share applies.*

See Summary Plan Descriptions (SPDs) for Exclusions