PLAN YEAR 7/01/2024 - 6/30/2025

County of Moore Schedule of Medical Benefits MC01	In-Network Member Responsibility	Out-of-Network Member Responsibility
Deductible (Plan Year)		
Individual	$1,500	$3,000 [Applies to all benefits except Emergency Services]
Family	$3,000	$6,000
Coinsurance After Deductible or Copayment	30%	40% of Maximum Allowable Payment
MEDICAL Out of Pocket (OOP) Maximum		
Individual-Medical Benefits	$5,000	$9,000
Family-Medical Benefits	$10,000	$18,000
PRESCRIPTION Out of Pocket (OOP) Maximum		
Individual- Prescription Drug Benefits	$1,500	$3,000
Family- Prescription Drug Benefits	$3,000	$6,000
Only Deductible, Coinsurance and Copays apply to OOP maximum. Please note that there are separate Out of Pocket Maximums for In-Network benefits and Out-of-Network benefits.	**Note: Certain covered benefits require prior authorization. Please refer to your Summary Plan Document or call Member Services for details.**	The member may be billed for the difference, if any, between the Actual Charges and the Maximum Allowable Payment and this difference is not applied to the Out of Pocket Maximum.
PHYSICIAN SERVICES	**PHYSICIAN SERVICES**	**PHYSICIAN SERVICES**
Office Visit: Primary Care / OBGYN / Pediatrician / Behavioral Health / Chemical Dependency Services	YOU PAY $0 visits 1-3, then $35 visits 4-unlimited	YOU PAY: 40% Coinsurance after Deductible
Specialist office visit	YOU PAY $70 Copayment	YOU PAY: 40% Coinsurance after Deductible
FirstHealth on the Go TeleMedicine	YOU PAY $0 visits 1-3, then $10 visits 4-unlimited	YOU PAY: 40% Coinsurance after Deductible
Allergy testing	YOU PAY $70 Copayment	YOU PAY: 40% Coinsurance after Deductible
Maternity services provided in physician office before, during, and after delivery	YOU PAY $0 Copayment	YOU PAY: 40% Coinsurance after Deductible
Surgical services performed in a Physician office	YOU PAY $35 Copayment Primary Care / OBGYN / Pediatrician YOU PAY $70 Copayment Specialist	YOU PAY: 40% Coinsurance after Deductible
Diagnostic procedures and tests performed in Physician office	YOU PAY $0	YOU PAY: 40% Coinsurance after Deductible
Infusion therapy (including drugs) and other non self injectables in a Physician office .	YOU PAY $70 Copayment	YOU PAY: 40% Coinsurance after Deductible
Preventive services listed and updated at www.uspreventiveservicestaskforce.org, such as: annual physical exam and certain other wellness visits, PAP smears, screening mammograms, screening colonoscopy, PSA tests, prescription contraceptive drugs or devices, outpatient contraceptive services and certain routine immunizations.	YOU PAY $0	NOT COVERED
Hearing Services including exams, tests, hearing aides and implantable devices	YOU PAY 30% Coinsurance. Deductible Waived	NOT COVERED
Family planning services (including injectables)	YOU PAY $35 Copayment	YOU PAY: 40% Coinsurance after Deductible
Covered immunizations **Self injectables are covered under Prescription Drug benefit only**	YOU PAY $0	NOT COVERED
Allergy Injectables.	YOU PAY 30% Coinsurance after Deductible	YOU PAY: 40% Coinsurance after Deductible

The term Physician also includes physician extenders.

County of Moore Schedule of Medical Benefits	In-Network Member Responsibility	Out-of-Network Member Responsibility
OUTPATIENT SERVICES	**OUTPATIENT SERVICES**	**OUTPATIENT SERVICES**
Diagnostic procedures and tests performed in an outpatient hospital setting	YOU PAY $0	NOT COVERED
MRI/CT scans/ PET scans/ and cardiac catherization services	YOU PAY 30% Coinsurance after Deductible	YOU PAY: 40% Coinsurance after Deductible
Physical therapy, occupational therapy, and speech therapy	YOU PAY 30% Coinsurance after Deductible	YOU PAY: 40% Coinsurance after Deductible
Chiropractic services:	YOU PAY 30% Coinsurance. Deductible Waived	YOU PAY: 40% Coinsurance. Deductible Waived
Infusion therapy (including drugs) and other non self injectables in an outpatient facility.	YOU PAY 30% Coinsurance after Deductible	YOU PAY: 40% Coinsurance after Deductible
Dialysis, chemotherapy and other therapies, including in Physician's office	YOU PAY 30% Coinsurance after Deductible	YOU PAY: 40% Coinsurance after Deductible
Home Health Care: Limit of 100 visits per year (In-Network and Out-of-Network visits are combined).	YOU PAY 30% Coinsurance after Deductible	YOU PAY: 40% Coinsurance after Deductible
Durable medical equipment including diabetic supplies	YOU PAY 30% Coinsurance after Deductible	YOU PAY: 40% Coinsurance after Deductible
Contraceptive devices including but not limited to implants and IUD	YOU PAY $0	YOU PAY: 40% Coinsurance after Deductible
Orthotics/Prosthetics	YOU PAY 30% Coinsurance after Deductible	YOU PAY: 40% Coinsurance after Deductible
Hospice services	YOU PAY 30% Coinsurance after Deductible	YOU PAY: 40% Coinsurance after Deductible
Other outpatient services	YOU PAY 30% Coinsurance after Deductible	YOU PAY: 40% Coinsurance after Deductible
Outpatient Hospital Surgery (Does not include surgery done in a Physician's office)	YOU PAY 30% Coinsurance after Deductible	YOU PAY: 40% Coinsurance after Deductible
HOSPITAL SERVICES	**HOSPITAL SERVICES**	**HOSPITAL SERVICES**
Hospital services: room and board (semiprivate; private room when ordered by Physician), intensive care, coronary care, neonatal intensive care, surgical services, dialysis, radiation therapy, and other inpatient charges such as operating room, drugs, x-ray, lab, supplies, and anesthesia including attending and consulting Physician services	YOU PAY 30% Coinsurance after Deductible	YOU PAY: 40% Coinsurance after Deductible
Skilled Nursing Facility: limited to 30 days per cause (In-Network and Out-of-Network combined)	YOU PAY 30% Coinsurance after Deductible	YOU PAY: 40% Coinsurance after Deductible
Rehabilitation services: limited to 30 day maximum per year (In-Network and Out-of-Network combined)	YOU PAY 30% Coinsurance after Deductible	YOU PAY: 40% Coinsurance after Deductible
Travel and Housing for Approved Transplant Services	$10,000 Lifetime Benefit	NOT COVERED
Approved Transplant Services	YOU PAY 30% Coinsurance after Deductible	YOU PAY: 40% Coinsurance after Deductible
Bariatric Surgery	YOU PAY 30% Coinsurance after Deductible	YOU PAY: 40% Coinsurance after Deductible

The term Physician also includes physician extenders.

County of Moore Schedule of Medical Benefits	In-Network Member Responsibility	Out-of-Network Member Responsibility
EMERGENCY SERVICES	**EMERGENCY SERVICES**	**EMERGENCY SERVICES**
Ambulance services when Emergency Medical Services required, including air ambulance when Medically Necessary and/or ordered by a Participating Physician	YOU PAY: 30% Coinsurance after Deductible	YOU PAY: 30% Coinsurance after Deductible
Emergency Medical Services received at Hospital emergency department	YOU PAY $250 copayment, then 30% Coinsurance after Deductible (Copay waived if admitted within 24 hours)	YOU PAY $250 copayment, then 30% Coinsurance after Deductible (Copay waived if admitted within 24 hours)
Urgent Care Facility services	YOU PAY: 30% Coinsurance after Deductible	YOU PAY: 30% Coinsurance after Deductible
PRESCRIPTION DRUGS	**PRESCRIPTION DRUGS**	**PRESCRIPTION DRUGS**
Deductible for Brand Name Prescription Drugs (Plan Year) Individual Family	 $150 $300	
30 day supply dispensed by retail pharmacy	YOU PAY $10 preferred generic copay YOU PAY $10 non-preferred generic copay YOU PAY $45 preferred brand copay after Deductible YOU PAY $60 non-preferred brand copay after Deductible YOU PAY $45 preferred specialty drug copay after Deductible YOU PAY $60 non-preferred specialty drug copay after Deductible	Covered persons are required to pay the full cost of prescription drugs & submit a reimbursement form to Optum Rx. If determined to be an eligible expense, covered persons will be reimbursed up to the applicable In-Network (contracted) provider prescription drug benefit level.
90 day supply - mail order or from select pharmacies Note: specialty drugs limited to 30 day supply	YOU PAY $30 preferred generic copay YOU PAY $30 non-preferred generic copay YOU PAY $135 preferred brand copay after Deductible YOU PAY $180 non-preferred brand copay after Deductible	
Age limit for Eligible Dependents is 26		**Notice: Actual expenses for Covered Services may exceed the stated Coinsurance percentage because actual Provider charges may not be used to determine plan and Member payment obligations.**

THIS IS A SUMMARY ONLY.
BENEFIT DETERMINATIONS ARE BASED ON THE TERMS AND CONDITIONS OF THE SUMMARY PLAN DOCUMENT.

PLEASE REFER TO THE PRIOR AUTHORIZATION LIST FOR MORE INFORMATION ABOUT WHICH SERVICES REQUIRE PRIOR AUTHORIZATION.

Some health care services are subject to Prior Authorization and will be provided only if the services provided are Medically Necessary and appropriate for the treatment, maintenance or improvement of the Covered Person's health.

The term Physician also includes physician extenders.