

# 2018 Medical plan benefit summary



## Endeavor Providence Gold 1000

|  | In-network you pay                                   | Out-of-network you pay            |
|--|--|-----------------------------------|
| <b>Calendar year costs</b>                         |  |                                   |
| Deductible per person                              | \$1,000  | \$3,000                           |
| Deductible per family                              | \$2,000  | \$6,000                           |
| Out-of-pocket max per person                       | \$7,000  | \$21,000                          |
| Out-of-pocket max per family                       | \$14,000   | \$42,000                          |
| <b>Care &amp; services</b>                         |  |                                   |
| Preventive care visit <sup>1</sup>                 | \$0/visit  | 50% after deductible              |
| Primary care provider (PCP) office visit           | \$20/visit   | 50% after deductible              |
| Specialist office visit                            | \$40/visit   | 50% after deductible              |
| Urgent care visit                                  | \$20/visit   | 50% after deductible              |
| Outpatient diagnostic X-ray & lab                  | 20%  | 50% after deductible              |
| Emergency room visit                               | \$250/20%/visit                                      | \$250/20%/visit                   |
| Ambulance  | 20% after deductible                                 | 20% after deductible              |
| Inpatient/outpatient Care                          | 20% after deductible                                 | 50% after deductible              |
| Outpatient mental health/chemical dependency visit | \$20/visit   | 50% after deductible              |
| Physical, speech or occupational therapy visit     | \$40/visit   | 50% after deductible              |
| Alternative care visit <sup>2</sup>                | \$20/visit   | 50% after deductible              |
| Embedded pediatric dental care                     | Included for members under age 19                    | Included for members under age 19 |
| Pediatric vision exam                              | 20%  | 50% after deductible              |
| Pediatric vision hardware                          | 20%  | 50% after deductible              |
| <b>Prescription medications<sup>3</sup></b>        |  |                                   |
| Value  | \$2  | \$2                               |
| Select   | \$20   | \$20                              |
| Preferred  | \$40   | \$40                              |
| Brand  | \$80   | \$80                              |
| Specialty  | 45%  | Not covered                       |
| <b>Features</b>                                    |  |                                   |
| Metallic level                                     | ● Gold   |                                   |
| Medicare Part D creditable coverage                | Yes  |                                   |
| Plan enrollment options                            | Direct through Moda Health or through HealthCare.gov |                                   |
| Provider network                                   | Endeavor Providence/MedImpact                        |                                   |

<sup>1</sup> For services as required under the Affordable Care Act

<sup>2</sup> Covers medically necessary spinal manipulations and acupuncture care

<sup>3</sup> 90-day supply when filled at a retail or mail-order pharmacy. Copay amounts are per 30-day supply. Some medications require special fulfillment through an exclusive pharmacy provider.

## Limitations

- Alternative care limited to 12 acupuncture and 12 spinal manipulation visits per calendar year
- Authorization by Moda Health required for all medical and surgical admissions and some outpatient services and medications, chiropractic, spinal manipulation and outpatient rehabilitation
- Coordination of benefits. When a member has other health coverage, combined benefits for all plans is limited to the maximum plan allowance for all covered services
- Home healthcare limited to 130 visits per calendar year
- Hospice benefits limited to 10 days of inpatient care and 240 hours of respite care
- If a group's size is less than 20 employees any expense that is actually paid under Medicare, or would have paid under Medicare Part B had the member enrolled in Medicare, will be reduced by the amount Medicare paid or would have paid.
- Inpatient rehabilitative and chronic pain care is limited to 30 days per calendar year; outpatient rehabilitation and habilitation benefits are limited to 45 sessions per calendar year (the limit does not apply to members under 21 with autism spectrum disorders). Limits apply separately to rehabilitative and habilitation services.
- Orthodontia limited to dependent children under age 19 only when medically necessary
- Prescriptions, maximum 90-day supply retail and mail order, and 30 days specialty pharmacy
- Skilled nursing facility limited to 60 days per calendar year
- Transplants must be performed at an Exclusive Center of Excellence facility to be eligible for coverage. Round-trip transportation and lodging up to \$7,500 per transplant
- Vision exam and glasses or contacts covered once per calendar year for members under age 19

## Exclusions

- Any expense that results from an act of declared or undeclared war or armed aggression
- Any expense you or your dependents do not have to pay
- Care outside the United States, other than emergency care
- Charges above the maximum plan allowance
- Cosmetic services and supplies (exception for reconstructive surgery after a mastectomy and some medically necessary complications of reconstructive surgeries)
- Court-ordered services, except when medically necessary
- Custodial care
- Dental examinations and treatment over age 18 (exception for accidental injury)
- Experimental or investigational treatment, except routine costs for qualified clinical trials
- Infertility (services or supplies for treatment of, including reversal of sterilization)
- Instruction programs, except as provided for under the health education services benefit
- Intellectual disability
- Massage or massage therapy
- Naturopathic and homeopathic remedies
- 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
- Personality disorders
- Professional athletic events
- Services or supplies available under any city, county, state or federal law, except Medicaid
- Services or supplies for which an employer is required by law to provide benefits, even if members choose not to accept those benefits
- Services provided by the patient or a member of the patient's immediate family, other than services by a dental provider
- Temporomandibular Joint Syndrome (TMJ)
- Treatment for sexual dysfunction and paraphilic disorders
- 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.*

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