

# Bronze > Be Balanced (Connexus)

|  | In-network, you pay   | Out-of-network, you pay |
|--|---|-------------------------|
| Calendar year costs                              |   |                         |
| Deductible per person                            | \$4,250   | \$8,500                 |
| Deductible per family                            | \$8,500   | \$17,000                |
| Out-of-pocket max per person                     | \$6,600   | \$13,200                |
| Out-of-pocket max per family                     | \$13,200  | \$26,400                |
| Care & services                                  |   |                         |
| Preventive care <sup>2</sup>                     | \$0/visit <sup>1</sup>  | 50%                     |
| Primary care physician (PCP) office visit        | \$35/visit <sup>1</sup> for first 3 visits,<br>35% subsequent visits <sup>3</sup> | 50%                     |
| Specialist office visit <sup>4</sup>             | 35%   | 50%                     |
| Urgent care visit                                | \$35/visit <sup>1</sup> for first 3 visits,<br>35% subsequent visits <sup>3</sup> | 50%                     |
| Inpatient/outpatient care                        | 35%   | 50%                     |
| Outpatient diagnostic X-ray & lab                | 35%   | 50%                     |
| Outpatient mental health/<br>chemical dependency | 35%   | 50%                     |
| Emergency room                                   | 35%   | 35%                     |
| Ambulance  | 35%   | 35%                     |
| Physical, speech or occupational therapy         | 35%   | 50%                     |
| Alternative care <sup>5</sup>                    | 35% <sup>1</sup>  | 50%                     |
| Pediatric vision exam                            | 35% <sup>1</sup>  | 50%                     |
| Pediatric vision hardware                        | 35%   | 50%                     |
| Accident benefit                                 | Paid as any other illness subject to deductible/coinsurance                       |                         |
| Prescription medications                         |   |                         |
| Value  | \$2 <sup>1</sup>  | \$2 <sup>1</sup>        |
| Select   | \$15 <sup>1</sup>   | \$15 <sup>1</sup>       |
| Preferred  | 40%   | 40%                     |
| Brand  | 50%   | 50%                     |
| Specialty <sup>6</sup>                           | 50%   | Not covered             |
| Features   |   |                         |
| Plan tier  | Bronze  |                         |
| Plan enrollment options                          | Health Insurance Marketplace or Moda Health                                       |                         |
| Provider network                                 | Connexus  |                         |
| Travel network                                   | PHCS Healthy Directions   |                         |
| Embedded pediatric dental                        | Not included  |                         |

<sup>1</sup> Deductible waived

<sup>2</sup> For services as required under the Affordable Care Act

<sup>3</sup> Plan pays for first three office visits with a copay, which may be used for either PCP office visits or urgent care for illness or injury. Thereafter, the deductible and coinsurance apply.

<sup>4</sup> Includes naturopathic office visits

<sup>5</sup> Covers medically necessary acupuncture, chiropractic services and naturopathic substances

<sup>6</sup> Specialty medications must be accessed through our exclusive specialty pharmacy provider and require prior authorization.

## Limitations

- Alternative care subject to \$500 annual dollar maximum.
- Ambulance transportation limited to six trips per calendar year
- Authorization by Moda Health is required for all medical and surgical admissions and some outpatient services and medications
- Biofeedback limited to 10 visits per lifetime for tension or migraine headaches or urinary incontinence
- Coordination of benefits – when a member has more than one health plan, combined benefits for all plans is limited to the maximum plan allowance for all covered services
- Hearing aids and related services covered once every 48 months for members under age 26
- Hospice respite care limited to 30 days lifetime maximum, up to five days consecutive
- Prescriptions – maximum 30-day supply for retail and specialty pharmacy and 90 days for mail order medications
- Rehabilitation and habilitation benefits limited to 30 inpatient days and 30 outpatient sessions per calendar year. May be eligible for up to 60 days or sessions for treatment of neurologic conditions
- Skilled nursing facility limited to 60 days per year
- Transplants must be performed at an Exclusive Transplant Network facility to be eligible for coverage
- Vision exam and glasses or contacts covered once per year for members under age 19

## Exclusions

- 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 as required under Oregon statute
- Custodial care
- Dental examinations and treatment (except for accidental injury)
- Experimental or investigational treatment
- Infertility (services or supplies for treatment of, including reversal of sterilization)
- Instruction programs, except as provided under the outpatient diabetic instruction benefit
- Intellectual disability for members over age 18
- Massage or massage therapy
- 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
- Injury resulting from participating in professional athletic events
- Services or supplies available under any city, county, state or federal law, except Medicaid
- 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)
- 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 further 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.