

# Silver > Be Driven (Providence)



|  | In-network, you pay <sup>2</sup>   | Out-of-network, you pay |
|--|--|-------------------------|
| <b>Calendar year costs</b>                             |  |                         |
| Deductible per person                                  | \$2,500  | \$5,000                 |
| Deductible per family                                  | \$5,000  | \$10,000                |
| Out-of-pocket max per person                           | \$6,000  | \$12,000                |
| Out-of-pocket max per family                           | \$12,000   | \$24,000                |
| <b>Care &amp; services</b>                             |  |                         |
| Preventive care <sup>3</sup>                           | \$0/per visit <sup>1</sup>   | 50%                     |
| Primary care physician (PCP) office visit <sup>4</sup> | \$30/visit for first 5 visits <sup>1</sup> ,<br>35% subsequent visits <sup>7</sup> | 50%                     |
| Specialist office visit                                | 35%  | 50%                     |
| Urgent care visit                                      | \$30/visit for first 5 visits <sup>1</sup> ,<br>35% subsequent visits <sup>7</sup> | 50%                     |
| Inpatient/outpatient care                              | 35%  | 50%                     |
| Outpatient diagnostic X-ray and 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%  | 50%                     |
| Pediatric vision exam                                  | 35%  | 50%                     |
| Pediatric vision hardware                              | 35%  | 50%                     |
| Accident benefit                                       | Paid as any other illness subject to deductible/coinsurance                        |                         |
| <b>Prescription medications</b>                        |  |                         |
| Value  | \$2 <sup>1</sup>   | \$2 <sup>1</sup>        |
| Select   | \$10 <sup>1</sup>  | \$10 <sup>1</sup>       |
| Preferred  | 35% <sup>1</sup>   | 35% <sup>1</sup>        |
| Brand  | 45% <sup>1</sup>   | 45% <sup>1</sup>        |
| Specialty <sup>6</sup>                                 | 45% <sup>1</sup>   | Not Covered             |
| <b>Features</b>  |  |                         |
| Plan tier  | Silver   |                         |
| Plan enrollment options                                | Health Insurance Marketplace or Moda Health  |                         |
| Provider network                                       | Endeavor Providence network  |                         |
| Embedded pediatric dental                              | Included for members under age 19  |                         |

<sup>1</sup> Deductible waived

<sup>2</sup> Every licensed professional provider in Alaska is covered at the in-network benefit level. In-network cost sharing and 50% out-of-network cost sharing apply to most services outside of Alaska.

<sup>3</sup> For services as required under the Affordable Care Act

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

<sup>5</sup> Covers medically necessary spinal and other manipulations and acupuncture care

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

<sup>7</sup> Plan pays for first five 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.

## 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
- 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 health care limited to 130 visits per year
- Hospice benefits limited to 10 days of inpatient care and 240 hours of respite care
- Orthodontia limited to members under age 19 and subject to a 2-year exclusion period
- Prescriptions, maximum 90 day supply retail and mail order and 30 days specialty pharmacy
- 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).
- Skilled nursing facility limited to 60 days per calendar year
- Transplants must be performed at an Exclusive Transplant Network 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

- 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 except as specifically listed under rehabilitation and habilitation
- 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
- Sexual disorders, including sexual dysfunction or inadequacy and sex change procedures
- 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.

Note: This Alaska plan is at state review and is subject to changes.