

# 2018 Medical plan benefit summary



## Moda Health Beacon Gold 1500

	In-network you pay	Out-of-network you pay
<b>Calendar year costs</b>		
Deductible per person	\$1,500	\$6,000
Deductible per family	\$3,000	\$12,000
Out-of-pocket max per person	\$6,500	\$26,000
Out-of-pocket max per family	\$13,000	\$52,000
<b>Care &amp; services</b>		
Preventive care visit <sup>1</sup>	\$0/visit	50% after deductible
Primary care provider (PCP) office visit	\$25/visit	50% after deductible
Specialist office visit	\$50/visit	50% after deductible
Urgent care visit	\$25/visit	50% after deductible
Outpatient diagnostic X-ray & lab	25% after deductible	50% after deductible
Emergency room visit	25% after deductible	25% after deductible
Ambulance	25% after deductible	25% after deductible
Inpatient/outpatient Care	25% after deductible	50% after deductible
Outpatient mental health/chemical dependency visit	\$25/visit	50% after deductible
Physical, speech or occupational therapy visit	\$50/visit	50% after deductible
Alternative care visit <sup>2</sup>	Not covered	Not covered
Pediatric dental services	Not covered	Not covered
Pediatric vision exam	\$25/visit	50% after deductible
Pediatric vision hardware	25% after deductible	50% after deductible
Accident benefit	Paid as any other illness subject to deductible/coinsurance	
<b>Prescription medications<sup>3</sup></b>		
Value	\$2	\$2
Select	\$10	\$10
Preferred	40%	40%
Brand	50%	50%
Specialty	50%	Not covered
<b>Features</b>		
Metallic level	● Gold	
Plan enrollment options	Direct through Moda Health or through HealthCare.gov	
Provider network	Beacon Network	
Travel network	First Health Network	

<sup>1</sup> For services as required under the Affordable Care Act. Only mammograms, women's exams, Pap tests, prostate exams and PSA tests are covered out-of-network.

<sup>2</sup> Spinal manipulations and acupuncture care.

<sup>3</sup> Copay amounts are per 30-day supply.

## Limitations

- Ambulance transportation is limited to 6 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
- Hospice respite care limited to 30 days lifetime maximum, up to five days consecutive
- Infusion therapy – Some medications require use of an authorized provider to be eligible for coverage. Outpatient hospital setting is not covered for some medications.
- Medicare – Any expense that is actually paid under Medicare, or would have been paid under Medicare Part B if you had enrolled in Medicare, will have benefits reduced by the amount Medicare paid or would have paid.
- Prescriptions – If using a brand medication when a generic equivalent is available, the member will be responsible for the brand cost sharing plus the difference in cost between the generic and brand medication. Prescriptions are limited to a 30-day supply for retail and specialty pharmacy and 90 days for mail order. Some medications require special fulfillment through an exclusive pharmacy provider.
- Rehabilitation and habilitation benefits limited to 30 inpatient days and 30 outpatient sessions per calendar year. May be eligible for up to 60 days after acute head or spinal cord injury or 60 sessions for treatment of neurologic conditions. Limits apply separately to rehabilitative and habilitative services.
- Skilled nursing facility limited to 60 days per year
- Transplants must be performed at the authorized transplant facility to be eligible for coverage
- Vision exam and glasses or contacts covered once per year for members under age 19

## Exclusions

- Alternative care
- Care outside the United States, other than urgent or emergency care
- Charges above the maximum plan allowance
- Cosmetic services and supplies (exception for reconstructive surgery if medically necessary and not specifically excluded)
- Court-ordered sex offender treatment
- 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)
- Injury resulting from practicing for or participating in professional athletic events
- Instruction programs, except as provided under the outpatient diabetic instruction benefit
- Massage or massage therapy
- Naturopathic supplies, including herbal, naturopathic or homeopathic medicines, substances or devices and any other nonprescription supplements
- 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
- Services or supplies available under any city, county, state or federal law, except Medicaid
- Services provided by the patient
- Services provided by 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 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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