2020 Medical plan benefit summary

moda HEALTH

Moda Health Oregon Standard Silver (Beacon) CSV2		
	In-network you pay	Out-of-network you pay
Calendar year costs		
Deductible per person	$900	Not covered
Deductible per family	$1,800	Not covered
Out-of-pocket max per person	$2,700	Not covered
Out-of-pocket max per family	$5,400	Not covered
Care & services		
Preventive care visit	$0/visit	Not covered
Primary care provider (PCP) office visit	$15/visit	Not covered
Specialist office visit	$30/visit	Not covered
Urgent care visit	$40/visit	Not covered
Virtual care visit	Same as in-office visit	Not covered
Outpatient diagnostic X-ray & lab	10% after deductible	Not covered
Emergency room visit	10% after deductible	10% after deductible
Ambulance	10% after deductible	10% after deductible
Inpatient/outpatient Care	10% after deductible	Not covered
Outpatient mental health/chemical dependency visit	$15/visit	Not covered
Physical, speech or occupational therapy visit	$15/visit	Not covered
Acupuncture and spinal manipulation services	Not covered	Not covered
Embedded pediatric dental	No	No
Pediatric vision exam	$0/visit	Not covered
Pediatric vision hardware	$0	Not covered
Accident benefit	N/A	Not covered
Prescription medications[1]		
Value	$10	$10
Select	$10	$10
Preferred	$25	$25
Non-Preferred	50%	50%
Preferred Specialty	50%	Not covered
Non-Preferred Specialty	50%	Not covered
Features		
Metallic level	Silver	
Exchange	In	
Provider network	Beacon Network	
Travel network	First Health Network	
Service area	Clackamas, Clatsop, Columbia, Coos, Curry, Hood River, Jackson, Josephine, Marion, Multnomah, Polk, Tillamook, Wasco, Washington, Yamhill	
Additional benefits	N/A	

1 *Copay amounts are per 30-day supply.*

Limitations

- 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 you have more than one health plan, combined benefits for all plans is limited to the maximum plan allowance for all covered services
- Hearing aids limited to once every 3 years. Hearing tests limited to twice per year under age 4 and once per year age 4 and older.
- Hospice respite care limited to 30 days lifetime maximum, up to five days in a row
- 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 you use a brand medication when a generic equivalent is available, you will be responsible for the nonpreferred 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 must be purchased through an exclusive pharmacy provider.
- Preventive care – Cost sharing may apply to services not required under the Affordable Care Act
- Rehabilitation and habilitation benefits limited to 30 inpatient days and 30 outpatient sessions per calendar year. May be eligible for up to 60 outpatient 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

- Acupuncture
- Care outside the United States, other than 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 except when medically necessary to repair an accidental injury or for treatment of cancer
- Services or supplies available under any city, county, state or federal law, except Medicaid
- Services you provide to yourself
- Services provided by a member of your immediate family other than services by a dental provider
- Spinal manipulation
- Temporomandibular Joint Syndrome (TMJ)
- Vision surgery to change 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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Health plans in Oregon provided by Moda Health Plan, Inc.
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