

# 2019 Medical plan benefit summary



## Moda Health Cornerstone Silver 3000 CSV3

|  | In-network you pay  | Out-of-network you pay |
|--|---|------------------------|
| <b>Calendar year costs</b>                         |   |                        |
| Deductible per person                              | \$100   | Not covered            |
| Deductible per family                              | \$200   | Not covered            |
| Out-of-pocket max per person                       | \$500   | Not covered            |
| Out-of-pocket max per family                       | \$1,000   | Not covered            |
| <b>Care &amp; services</b>                         |   |                        |
| Preventive care visit                              | \$0/visit   | Not covered            |
| Primary care provider (PCP) office visit           | \$35/visit  | Not covered            |
| Specialist office visit                            | \$70/visit  | Not covered            |
| Urgent care visit                                  | \$35/visit  | Not covered            |
| Outpatient diagnostic X-ray & lab                  | 30% after deductible  | Not covered            |
| Emergency room visit                               | 30% after deductible  | 30% after deductible   |
| Ambulance  | 30% after deductible  | 30% after deductible   |
| Inpatient/outpatient Care                          | 30% after deductible  | Not covered            |
| Outpatient mental health/chemical dependency visit | \$35/visit  | Not covered            |
| Physical, speech or occupational therapy visit     | \$70/visit  | Not covered            |
| Acupuncture and spinal manipulation services       | \$35/visit  | Not covered            |
| Embedded pediatric dental                          | Yes   | Not covered            |
| Pediatric vision exam                              | \$35/visit  | Not covered            |
| Pediatric vision hardware                          | 30% after deductible  | Not covered            |
| Accident benefit                                   | 0%  | Not covered            |
| <b>Prescription medications<sup>1</sup></b>        |   |                        |
| Value  | \$2   | \$2                    |
| Select   | \$20  | \$20                   |
| Preferred  | 40%   | 40%                    |
| Non-Preferred                                      | 50% after deductible  | 50% after deductible   |
| Preferred Specialty                                | 40%   | Not covered            |
| Non-Preferred Specialty                            | 50% after deductible  | Not covered            |
| <b>Features</b>                                    |   |                        |
| Metallic level                                     | ● Silver  |                        |
| Exchange   | In  |                        |
| Provider network                                   | Cornerstone Network   |                        |
| Travel network                                     | First Health Network  |                        |
| Service area                                       | Clackamas, Multnomah, Washington  |                        |
| Additional benefits                                | Accident benefit: No cost share for the first \$1,000 within 90 days, deductible waived |                        |

<sup>1</sup> Copay amounts are per 30-day supply.

## Limitations

- Acupuncture and spinal manipulation is limited to \$1,000 annual maximum.
- 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 services are covered as required under state and federal law
- 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 days after acute head or spinal cord injury or 60 sessions for treatment of neurological 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

- 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
- 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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