2016 Medical plan benefit table

Moda Health Providence Caliber 2500		
	In-network you pay	Out-of-network you pay
Calendar year costs		
Deductible per person	$2,500	$5,000
Deductible per family	$5,000	$10,000
Out-of-pocket max per person	$6,850	$13,700
Out-of-pocket max per family	$13,700	$27,400
Care & services		
Preventive care visit[1]	0%	50% after deductible
Primary care provider (PCP) office visit	35%	50% after deductible
Specialist office visit	35%	50% after deductible
Urgent care visit	35%	50% after deductible
Outpatient diagnostic X-ray & lab	35% after deductible	50% after deductible
Emergency room visit	$250/35% after deductible	$250/35% after deductible
Ambulance	35% after deductible	35% after deductible
Inpatient/outpatient care	35% after deductible	50% after deductible
Outpatient mental health/chemical dependency visit	35%	50% after deductible
Physical, speech or occupational therapy visit	35%	50% after deductible
Alternative care visit[2]	35%	50% after deductible
Embedded pediatric dental care	Included for members under age 19; deductible waived for in-network preventive services.	
Pediatric vision exam	35%	50% after deductible
Pediatric vision hardware	35%	50% after deductible
Prescription medications[3]		
Value	$2	$2
Select	$20	$20
Preferred	35%	35%
Brand	45%	45%
Specialty	45%	Not covered
Features		
Metallic level	Silver	
Plan enrollment options	Direct through modahealth.com or through HealthCare.gov	
Medicare Part D creditable coverage	Yes	
Provider network	Endeavor Providence Network/MedImpact	

1 *For services as required under the Affordable Care Act*
2 *Covers medically necessary spinal manipulations and acupuncture care*
3 *90-day supply when filled at a retail or mail-order pharmacy. Copay amounts are per 30-day supply. Some medications require special fulfillment through an exclusive pharmacy provider.*

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 healthcare limited to 130 visits per calendar year
- Hospice benefits limited to 10 days of inpatient care and 240 hours of respite care
- Orthodontia limited to dependent children under age 19 and subject to a two-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
- Any expense that results from an act of declared or undeclared war or armed aggression
- Any expense you or your dependents do not have to pay
- Any expense paid in whole or in part by any other provision of the group health insurance plan provided by the policyholder

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.

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