2015 plan comparison guide

Groups of 1 – 50

Plans available Jan. 1, 2015, through Dec. 31, 2015

Alaska

DELTA DENTAL

moda HEALTH

Better health starts here

Hello. Welcome to Moda Health and Delta Dental of Alaska, the place you go when you want more than a health plan — because good health is about so much more than just the plan details.

You know your group's health relies on quality plans, programs, online tools and, most important, partnerships that help each person along the way. We have all of that and a little bit more — and we're excited to help your entire team start on a journey to be better.

For our part, we'll provide a network of doctors and specialists, expert health coaches, caring customer service reps and some of the greatest innovators in healthcare. For your part, we ask that the people in your group come ready to be the MVP of their health. Don't worry; we'll help inspire them.

Because together, we can be more. We can be better.

Gold tier plans

Gold tier plans	PPO 500		PPO 1000	
	In-network, members pay[2]	Out-of-network, members pay	In-network, members pay[2]	Out-of-network, members pay
Calendar year costs				
Deductible per person	$500	$1,000	$1,000	$2,000
Deductible per family	$1,000	$2,000	$2,000	$4,000
Out-of-pocket max per person	$4,000	$8,000	$4,000	$8,000
Out-of-pocket max per family	$8,000	$16,000	$8,000	$16,000
Care & services				
Preventive care[3]	$0/visit[1]	50%	$0/visit[1]	50%
Primary care physician (PCP) office visit[4]	$15/visit[1]	50%	$15/visit[1]	50%
Specialist office visit	$30/visit[1]	50%	$30/visit[1]	50%
Urgent care visit	$15/visit[1]	50%	$15/visit[1]	50%
Inpatient/outpatient care	20%	50%	20%	50%
Outpatient diagnostic X-ray & lab	20%[1]	50%	20%[1]	50%
Outpatient mental health/ chemical dependency	$15/visit[1]	50%	$15/visit[1]	50%
Emergency room	$200 copay + 20%/visit[1]	$200 copay + 20%/visit[1]	$200 copay + 20%/visit[1]	$200 copay + 20%/visit[1]
Ambulance	20%	20%	20%	20%
Physical, speech or occupational therapy	$30/visit[1]	50%	$30/visit[1]	50%
Alternative care[5]	$15/visit[1]	50%	$15/visit[1]	50%
Pediatric vision exam	20%[1]	50%	20%[1]	50%
Pediatric vision hardware	20%[1]	50%	20%[1]	50%
Prescription medications				
Value	$2[1]	$2[1]	$2[1]	$2[1]
Select	$10[1]	$10[1]	$10[1]	$10[1]
Preferred	$30[1]	$30[1]	$30[1]	$30[1]
Brand	$60[1]	$60[1]	$60[1]	$60[1]
Specialty[6]	45%[1]	Not covered	45%[1]	Not covered
Features				
Plan tier	Gold		Gold	
Plan enrollment options	Health Insurance Marketplace or Moda Health		Health Insurance Marketplace or Moda Health	
Provider network	Members can choose Endeavor Providence network or Endeavor Select network		Members can choose Endeavor Providence network or Endeavor Select network	
Embedded pediatric dental	Included for members under age 19		Included for members under age 19	

1 Deductible waived
2 Every licensed professional provider in Alaska is covered at the in-network benefit level. In-network cost sharing and 50 percent out-of-network cost sharing apply to most services outside of Alaska.
3 For services as required under the Affordable Care Act
4 Includes naturopathic office visits
5 Covers medically necessary spinal and other manipulations and acupuncture care
6 Specialty medications require prior authorization and must be accessed through a specialty pharmacy provider.

PPO 1500	
In-network, members pay[2]	Out-of-network, members pay
$1,500	$3,000
$3,000	$6,000
$4,000	$8,000
$8,000	$16,000
$0/visit[1]	50%
$15/visit[1]	50%
$30/visit[1]	50%
$15/visit[1]	50%
20%	50%
20%[1]	50%
$15/visit[1]	50%
$200 copay + 20%/visit[1]	$200 copay + 20%/visit[1]
20%	20%
$30/visit[1]	50%
$15/visit[1]	50%
20%[1]	50%
20%[1]	50%
$2[1]	$2[1]
$10[1]	$10[1]
$30[1]	$30[1]
$60[1]	$60[1]
45%[1]	Not covered
Gold	
Health Insurance Marketplace or Moda Health	
Members can choose Endeavor Providence network or Endeavor Select network	
Included for members under age 19	

Silver tier plans

Silver tier plans	PPO 2000		PPO 3000	
	In-network, members pay[2]	Out-of-network, members pay	In-network, members pay[2]	Out-of-network, members pay
Calendar year costs				
Deductible per person	$2,000	$4,000	$3,000	$6,000
Deductible per family	$4,000	$8,000	$6,000	$12,000
Out-of-pocket max per person	$6,600	$13,200	$6,600	$13,200
Out-of-pocket max per family	$13,200	$26,400	$13,200	$26,400
Care & services				
Preventive care[3]	$0/visit[1]	50%	$0/visit[1]	50%
Primary care physician (PCP) office visit[4]	$25/visit[1]	50%	$25/visit[1]	50%
Specialist office visit	$45/visit[1]	50%	$45/visit[1]	50%
Urgent care visit	$25/visit[1]	50%	$25/visit[1]	50%
Inpatient/outpatient care	20%	50%	20%	50%
Outpatient diagnostic X-ray & lab	20%[1]	50%	20%[1]	50%
Outpatient mental health/ chemical dependency	$25/visit[1]	50%	$25/visit[1]	50%
Emergency room	$200 copay + 20%/visit[1]	$200 copay + 20%/visit[1]	$200 copay + 20%/visit[1]	$200 copay + 20%/visit[1]
Ambulance	20%	20%	20%	20%
Physical, speech or occupational therapy	$45/visit[1]	50%	$45/visit[1]	50%
Alternative care[5]	$25/visit[1]	50%	$25/visit[1]	50%
Pediatric vision exam	20%[1]	50%	20%[1]	50%
Pediatric vision hardware	20%[1]	50%	20%[1]	50%
Prescription medications				
Value	$2[1]	$2[1]	$2[1]	$2[1]
Select	$15[1]	$15[1]	$15[1]	$15[1]
Preferred	35%[1]	35%[1]	35%[1]	35%[1]
Brand	45%[1]	45%[1]	45%[1]	45%[1]
Specialty[6]	45%[1]	Not covered	45%[1]	Not covered
Features				
Plan tier	Silver		Silver	
Plan enrollment options	Health Insurance Marketplace or Moda Health		Health Insurance Marketplace or Moda Health	
Provider network	Members can choose Endeavor Providence network or Endeavor Select network		Members can choose Endeavor Providence network or Endeavor Select network	
Embedded pediatric dental	Included for members under age 19		Included for members under age 19	

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Value 1500		Value 2000		Value 3000	
In-network, members pay[2]	Out-of-network, members pay	In-network, members pay[2]	Out-of-network, members pay	In-network, members pay[2]	Out-of-network, members pay
$1,500	$3,000	$2,000	$4,000	$3,000	$6,000
$3,000	$6,000	$4,000	$8,000	$6,000	$12,000
$6,600	$13,200	$6,600	$13,200	$6,600	$13,200
$13,200	$26,400	$13,200	$26,400	$13,200	$26,400
$0/visit[1]	50%	$0/visit[1]	50%	$0/visit[1]	50%
$35/visit[1]	50%	$35/visit[1]	50%	$35/visit[1]	50%
$60/visit[1]	50%	$60/visit[1]	50%	$60/visit[1]	50%
$35/visit[1]	50%	$35/visit[1]	50%	$35/visit[1]	50%
30%	50%	30%	50%	30%	50%
30%[1]	50%	30%[1]	50%	30%[1]	50%
$35/visit[1]	50%	$35/visit[1]	50%	$35/visit[1]	50%
$200 copay + 30%/visit	$200 copay + 30%/visit	$200 copay + 30%/visit	$200 copay + 30%/visit	$200 copay + 30%/visit	$200 copay + 30%/visit
30%	30%	30%	30%	30%	30%
$60/visit[1]	50%	$60/visit[1]	50%	$60/visit[1]	50%
$35/visit[1]	50%	$35/visit[1]	50%	$35/visit[1]	50%
30%[1]	50%	30%[1]	50%	30%[1]	50%
30%[1]	50%	30%[1]	50%	30%[1]	50%
$2[1]	$2[1]	$2[1]	$2[1]	$2[1]	$2[1]
$15[1]	$15[1]	$15[1]	$15[1]	$15[1]	$15[1]
35%[1]	35%[1]	35%[1]	35%[1]	35%[1]	35%[1]
45%[1]	45%[1]	45%[1]	45%[1]	45%[1]	45%[1]
45%[1]	Not covered	45%[1]	Not covered	45%[1]	Not covered
Silver		Silver		Silver	
Health Insurance Marketplace or Moda Health		Health Insurance Marketplace or Moda Health		Health Insurance Marketplace or Moda Health	
Members can choose Endeavor Providence network or Endeavor Select network		Members can choose Endeavor Providence network or Endeavor Select network		Members can choose Endeavor Providence network or Endeavor Select network	
Included for members under age 19		Included for members under age 19		Included for members under age 19	

Silver tier plans (continued)

Silver tier plans	Value 4000		Beneficial 1500	
	In-network, members pay[2]	Out-of-network, members pay	In-network, members pay[2]	Out-of-network, members pay
Calendar year costs				
Deductible per person	$4,000	$8,000	$1,500	$3,000
Deductible per family	$8,000	$16,000	$3,000	$6,000
Out-of-pocket max per person	$6,600	$13,200	$5,500	$11,000
Out-of-pocket max per family	$13,200	$26,400	$11,000	$22,000
Care & services				
Preventive care[3]	$0/visit[1]	50%	$0/visit[1]	50%
Primary care physician (PCP) office visit[4]	$35/visit[1]	50%	$35[1] for first 5 visits, 30% for subsequent visits[7]	50%
Specialist office visit	$60/visit[1]	50%	30%	50%
Urgent care visit	$35/visit[1]	50%	$35[1] for first 5 visits, 30% for subsequent visits[7]	50%
Inpatient/outpatient care	30%	50%	30%	50%
Outpatient diagnostic X-ray & lab	30%[1]	50%	30%	50%
Outpatient mental health/ chemical dependency	$35/visit[1]	50%	30%	50%
Emergency room	$200 copay + 30%/visit	$200 copay + 30%/visit	$200 copay + 30%/visit	$200 copay + 30%/visit
Ambulance	30%	30%	30%	30%
Physical, speech or occupational therapy	$60/visit[1]	50%	30%	50%
Alternative care[5]	$35/visit[1]	50%	$40/visit[1]	50%
Pediatric vision exam	30%[1]	50%	30%[1]	50%
Pediatric vision hardware	30%[1]	50%	30%[1]	50%
Prescription medications				
Value	$2[1]	$2[1]	$2[1]	$2[1]
Select	$15[1]	$15[1]	$15[1]	$15[1]
Preferred	35%[1]	35%[1]	35%[1]	35%[1]
Brand	45%[1]	45%[1]	45%[1]	45%[1]
Specialty[6]	45%[1]	Not covered	45%[1]	Not covered
Features				
Plan tier	Silver		Silver	
Plan enrollment options	Health Insurance Marketplace or Moda Health		Health Insurance Marketplace or Moda Health	
Provider network	Members can choose Endeavor Providence network or Endeavor Select network		Members can choose Endeavor Providence network or Endeavor Select network	
Embedded pediatric dental	Included for members under age 19		Included for members under age 19	

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2 Every licensed professional provider in Alaska is covered at the in-network benefit level. In-network cost sharing and 50 percent out-of-network cost sharing apply to most services outside of Alaska.
3 For services as required under the Affordable Care Act
4 Includes naturopathic office visits
5 Covers medically necessary spinal and other manipulations and acupuncture care
6 Specialty medications require prior authorization and must be accessed through a specialty pharmacy provider.

Beneficial 2000		Beneficial 3000		HSA 2000	
In-network, members pay[2]	Out-of-network, members pay	In-network, members pay[2]	Out-of-network, members pay	In-network, members pay[2]	Out-of-network, members pay
$2,000	$4,000	$3,000	$6,000	$2,000	$4,000
$4,000	$8,000	$6,000	$12,000	$4,000[8]	$8,000[8]
$5,500	$11,000	$5,500	$11,000	$5,250	$10,500
$11,000	$22,000	$11,000	$22,000	$10,500	$21,000
$0/visit[1]	50%	$0/visit[1]	50%	$0/visit[1]	50%
$35[1] for first 5 visits, 30% for subsequent visits[7]	50%	$35[1] for first 5 visits, 30% for subsequent visits[7]	50%	20%	50%
30%	50%	30%	50%	20%	50%
$35[1] for first 5 visits, 30% for subsequent visits[7]	50%	$35[1] for first 5 visits, 30% for subsequent visits[7]	50%	20%	50%
30%	50%	30%	50%	20%	50%
30%	50%	30%	50%	20%	50%
30%	50%	30%	50%	20%	50%
$200 copay + 30%/visit	$200 copay + 30%/visit	$200 copay + 30%/visit	$200 copay + 30%/visit	20%	20%
30%	30%	30%	30%	20%	20%
30%	50%	30%	50%	20%	50%
$40/visit[1]	50%	$40/visit[1]	50%	20%	50%
30%[1]	30%[1]	30%[1]	50%	20%	50%
30%[1]	30%[1]	30%[1]	50%	20%	50%
$2[1]	$2[1]	$2[1]	$2[1]	$2[1]	$2[1]
$15[1]	$15[1]	$15[1]	$15[1]	30%	30%
35%[1]	35%[1]	35%[1]	35%[1]	30%	30%
45%[1]	45%[1]	45%[1]	45%[1]	45%	45%
45%[1]	Not covered	45%[1]	Not covered	45%	Not covered
Silver		Silver		Silver	
Health Insurance Marketplace or Moda Health		Health Insurance Marketplace or Moda Health		Health Insurance Marketplace or Moda Health	
Members can choose Endeavor Providence network or Endeavor Select network		Members can choose Endeavor Providence network or Endeavor Select network		Members can choose Endeavor Providence network or Endeavor Select network	
Included for members under age 19		Included for members under age 19		Included for members under age 19	

7 Plan pays for the 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.
8 HSA plans require that the family deductible be met prior to benefits being paid when the subscriber and a spouse, or one or more dependents, are enrolled.

Bronze tier plans

Bronze tier plans	Beneficial 4000		Beneficial 4500	
	In-network, members pay[2]	Out-of-network, members pay	In-network, members pay[2]	Out-of-network, members pay
Calendar year costs				
Deductible per person	$4,000	$8,000	$4,500	$9,000
Deductible per family	$8,000	$16,000	$9,000	$18,000
Out-of-pocket max per person	$6,600	$13,200	$6,600	$13,200
Out-of-pocket max per family	$13,200	$26,400	$13,200	$26,400
Care & services				
Preventive care[3]	$0/visit[1]	50%	$0/visit[1]	50%
Primary care physician (PCP) office visit[4]	$35[1] for first 3 visits, 50% for subsequent visits[7]	50%	$35[1] for first 3 visits, 50% for subsequent visits[7]	50%
Specialist office visit	50%	50%	50%	50%
Urgent care visit	$35[1] for first 3 visits, 50% for subsequent visits[7]	50%	$35[1] for first 3 visits, 50% for subsequent visits[7]	50%
Inpatient/outpatient care	50%	50%	50%	50%
Outpatient diagnostic X-ray & lab	50%	50%	50%	50%
Outpatient mental health/ chemical dependency	50%	50%	50%	50%
Emergency room	$200 copay + 50%/visit	$200 copay + 50%/visit	$200 copay + 50%/visit	$200 copay + 50%/visit
Ambulance	50%	50%	50%	50%
Physical, speech or occupational therapy	50%	50%	50%	50%
Alternative care[5]	$50/visit[1]	50%	$50/visit[1]	50%
Pediatric vision exam	50%[1]	50%	50%[1]	50%
Pediatric vision hardware	50%[1]	50%	50%[1]	50%
Prescription medications				
Value	$2[1]	$2[1]	$2[1]	$2[1]
Select	35%	35%	35%	35%
Preferred	35%	35%	35%	35%
Brand	45%	45%	45%	45%
Specialty[6]	45%	Not covered	45%	Not covered
Features				
Plan tier	Bronze		Bronze	
Plan enrollment options	Health Insurance Marketplace or Moda Health		Health Insurance Marketplace or Moda Health	
Provider network	Members can choose Endeavor Providence network or Endeavor Select network		Members can choose Endeavor Providence network or Endeavor Select network	
Embedded pediatric dental	Included for members under age 19		Included for members under age 19	

1 Deductible waived
2 Every licensed professional provider in Alaska is covered at the in-network benefit level. In-network cost sharing and 50 percent out-of-network cost sharing apply to most services outside of Alaska.
3 For services as required under the Affordable Care Act
4 Includes naturopathic office visits
5 Covers medically necessary spinal and other manipulations and acupuncture care
6 Specialty medications require prior authorization and must be accessed through a specialty pharmacy provider.

Beneficial 5000		HSA 3000		HSA 4000	
In-network, members pay[2]	Out-of-network, members pay	In-network, members pay[2]	Out-of-network, members pay	In-network, members pay[2]	Out-of-network, members pay
$5,000	$10,000	$3,000	$6,000	$4,000	$8,000
$10,000	$20,000	$6,000[4]	$12,000[4]	$8,000[8]	$16,000[8]
$6,600	$13,200	$6,450	$12,900	$6,450	$12,900
$13,200	$26,400	$12,900	$25,800	$12,900	$25,800
$0/visit[1]	50%	$0/visit[1]	50%	$0/visit[1]	50%
$35[1] for first 3 visits, 50% for subsequent visits[7]	50%	30%	50%	30%	50%
50%	50%	30%	50%	30%	50%
$35[1] for first 3 visits, 50% for subsequent visits[7]	50%	30%	50%	30%	50%
50%	50%	30%	50%	30%	50%
50%	50%	30%	50%	30%	50%
50%	50%	30%	50%	30%	50%
$200 copay + 50%/visit	$200 copay + 50%/visit	30%	30%	30%	30%
50%	50%	30%	30%	30%	30%
50%	50%	30%	50%	30%	50%
$50/visit[1]	50%	30%	50%	30%	50%
50%[1]	30%[1]	30%	50%	30%	50%
50%[1]	30%[1]	30%	50%	30%	50%
$2[1]	$2[1]	$2[1]	$2[1]	$2[1]	$2[1]
35%	35%	40%	40%	40%	40%
35%	35%	40%	40%	40%	40%
45%	45%	45%	45%	45%	45%
45%	Not covered	45%	Not covered	45%	Not covered
Bronze		Bronze		Bronze	
Health Insurance Marketplace or Moda Health		Health Insurance Marketplace or Moda Health		Health Insurance Marketplace or Moda Health	
Members can choose Endeavor Providence network or Endeavor Select network		Members can choose Endeavor Providence network or Endeavor Select network		Members can choose Endeavor Providence network or Endeavor Select network	
Included for members under age 19		Included for members under age 19		Included for members under age 19	

7 Plan pays for the first three 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.
8 HSA plans require that the family deductible be met prior to benefits being paid when the subscriber and a spouse, or one or more dependents, are enrolled.

Bronze tier plans (continued)

Bronze tier plans	HSA 5000		HSA 6000	
	In-network, members pay[2]	Out-of-network, members pay	In-network, members pay[2]	Out-of-network, members pay
Calendar year costs				
Deductible per person	$5,000	$10,000	$6,000	$12,000
Deductible per family	$10,000[5]	$20,000[5]	$12,000[7]	$24,000[7]
Out-of-pocket max per person	$6,450	$12,900	$6,000	$12,000
Out-of-pocket max per family	$12,900	$25,800	$12,000	$24,000
Care & services				
Preventive care[3]	$0/visit[1]	50%	$0/visit[1]	0%
Primary care physician (PCP) office visit[4]	30%	50%	0%	0%
Specialist office visit	30%	50%	0%	0%
Urgent care visit	30%	50%	0%	0%
Inpatient/outpatient care	30%	50%	0%	0%
Outpatient diagnostic X-ray & lab	30%	50%	0%	0%
Outpatient mental health/ chemical dependency	30%	50%	0%	0%
Emergency room	30%	30%	0%	0%
Ambulance	30%	30%	0%	0%
Physical, speech or occupational therapy	30%	50%	0%	0%
Alternative care[5]	30%	50%	0%	0%
Pediatric vision exam	30%	50%	0%	0%
Pediatric vision hardware	30%	50%	0%	0%
Prescription medications				
Value	$2[1]	$2[1]	$2[1]	$2[1]
Select	40%	40%	0%	0%
Preferred	40%	40%	0%	0%
Brand	45%	45%	0%	0%
Specialty[6]	45%	Not covered	0%	Not covered
Features				
Plan tier	Bronze		Bronze	
Plan enrollment options	Health Insurance Marketplace or Moda Health		Health Insurance Marketplace or Moda Health	
Provider network	Members can choose Endeavor Providence network or Endeavor Select network		Members can choose Endeavor Providence network or Endeavor Select network	
Embedded pediatric dental	Included for members under age 19		Included for members under age 19	

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4 Includes naturopathic office visits
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6 Specialty medications require prior authorization and must be accessed through a specialty pharmacy provider.
7 HSA plans require that the family deductible be met prior to benefits being paid when the subscriber and a spouse, or one or more dependents, are enrolled.


Together, we
can find a way to
better health.

Dental plans

Dental plans	Delta Dental Premier Plan B3x501 | B3x50 | B3x502		Delta Dental Premier Plan W3x50	
Calendar year costs				
Deductible per person	$50 / $150 family[1]		$50 / $150 family[1]	
Out-of-pocket maximum per person	None		None	
Annual maximum	$1,000 | $1,500 | $2,000		$1,500	
	What members pay		What members pay	
Class 1	Ages 0 – 18	Ages 19+	Ages 0 – 18	Ages 19+
Exams & X-rays	Not covered	0%[1]	Not covered	20%[1]
Cleanings	Not covered	0%[1]	Not covered	20%[1]
Sealants	Not covered	0%[1]	Not covered	20%[1]
Topical fluoride	Not covered	0%[1]	Not covered	20%[1]
Space maintainers	Not covered	0%[1]	Not covered	20%[1]
Class 2				
Restorative fillings	Not covered	20%	Not covered	20%
Oral surgery	Not covered	20%	Not covered	20%
Endodontics	Not covered	20%	Not covered	20%
Periodontics	Not covered	20%	Not covered	20%
Class 3				
Restorative crowns	Not covered	50%	Not covered	50%
Partial and complete dentures	Not covered	50%	Not covered	50%
Implants	Not covered	50%	Not covered	50%
Features				
Provider network	Delta Dental Premier Network		Delta Dental Premier Network	

1 Deductible waived for Class 1 services

Delta Dental Premier Plan W3x501	
$50 / $150 family[1]	
None	
$1,000	
What members pay	
Ages 0 – 18	Ages 19+
Not covered	20%[1]
Not covered	20%[1]
Not covered	20%[1]
Not covered	20%[1]
Not covered	20%[1]
Not covered	20%
Not covered	20%
Not covered	20%
Not covered	20%
Not covered	50%
Not covered	50%
Not covered	50%
Delta Dental Premier Network	

DELTA DENTAL

Limitations

Diagnostic and preventive

- Exam once in a six-month period
- Bitewing X-rays once in a 12-month period
- Full-mouth or panoramic X-rays once in a five-year period
- Cleaning (prophylaxis or periodontal maintenance) once in a six-month period
- Fluoride once in a 12-month period for high-risk patients only
- Sealants limited to unrestored occlusal surface of permanent molars once per tooth in a five-year period

Basic and major

- Bridges and dentures once in a seven-year period
- Crowns and other cast restorations once in a seven-year period
- IV sedation or general anesthesia only with surgical procedures
- Scaling and root planing once in a two-year period
- Tooth-colored filings or crowns on back teeth limited to amount allowed for metallic restoration

Exclusions

- Anesthetics, analgesics, hypnosis and medications, including nitrous oxide
- Charges above the reimbursement amount
- Charting (including periodontal, gnathologic)
- Congenital or developmental malformations
- Cosmetic services
- Duplication and interpretation of X-rays
- Experimental or investigational treatment
- Hospital costs or other fees for facility or home care
- Instructions or training (including plaque control and oral hygiene or dietary instruction)
- Nightguards
- Orthodontia
- Precision attachments
- Rebuilding or maintaining chewing surfaces (misalignment or malocclusion) or stabilizing teeth
- Services or supplies available under any city, county, state or federal law, except Medicaid
- Services for members under age 19
- Temporomandibular joint syndrome (TMJ)
- Treatment not dentally necessary


When it comes
to better healthcare,
we think we can
do more together.

Vision plans

Vision plans*	VEO	V100	V1003
Calendar year			
Benefit maximum	$200	$200	$300
	What members pay		
Eye examinations (including refraction)	0%	0%	0%
Lenses	Not covered	0%[1]	0%[1]
Frames	Not covered	0%[1]	0%[1]

1 Contact lenses are covered in lieu of regular lenses and frames.

Limitations and exclusions

Only covered for the employee and any dependent age 19 and over.

Vision exam and hardware benefits are all subject to the calendar-year benefit maximum.

Percentages shown reflect what members pay for covered vision exam, lenses and frames, or contacts in lieu of lenses and frames.

Noncovered, excluded services are the member's responsibility and do not apply toward the calendar year benefit maximum.

No vision care benefits will be paid for the following services and supplies:

- Treatment of eyes for special procedures such as orthoptics and vision training
- Charges for fashion eyewear features such as flint glass or blended (except tints #1 and #2)
- Any extra charge for lenses with prisms, prism segs, slab-off and other special-purpose vision aids
- Nonprescription lenses
- Medical or surgical treatment of the eyes
- Services and supplies that are payable under a workers' compensation or occupational disease law
- Any expense a member did not have to pay because of discounts received or other promotions

**An option including the Alaska-mandated vision plan is also available.*

Hearing plans

Hearing plan	AKH80
Three-year period	
Benefit maximum	$800
	What members pay
Otological (ear) exam	20%[1]
Audiological (hearing) exam	20%[1]
Hearing aid (monaural or binaural)	20%[1]
Ear molds	20%[1]
Hearing aid instruments	20%[1]
Initial batteries, cords and other necessary supplementary equipment	20%[1]
Warranty	20%[1]
Follow-up consultation (within 30 days of hearing aid delivery)	20%[1]
Repairs, servicing or alteration of hearing aid equipment	20%[1]

1 Deductible waived

Limitations and exclusions

The benefit maximum is provided once every three years beginning with the date of the otological examination. The plan allows you to choose any licensed physician, audiologist or surgeon.

No hearing care benefits will be paid for the following services and supplies:

- Replacement of a hearing aid, for any reason, more than once in a three-year period
- Batteries or other supplementary equipment other than those obtained upon purchase of the hearing aid
- A hearing aid exceeding the specifications prescribed for correction of hearing loss
- Expenses incurred after coverage ends, unless you order a hearing aid before the termination and receive it within 90 days of the end date
- Services and supplies that are payable under a workers' compensation or occupational disease law

Limitations and exclusions for medical plans

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 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 Policy holder

Questions?

We're here to help. Contact a Moda Health-appointed agent, or call us toll-free at 888-374-8910. TTY users, please call 711.

modahealth.com

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 the agent or Moda Health.

These benefits and Moda Health policies are subject to change in order to be compliant with state and federal guidelines.
Health plans in Alaska provided by Moda Health Plan, Inc. Dental plans in Alaska provided by Delta Dental of Alaska.

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