2021 Medical plan benefit summary



beductible per family \$1.000 \$3.000 beductible per family \$2.000 \$6,000 Dut-of-pocket max per family \$13.500 \$20.250 Dut-of-pocket max per family \$13.500 \$40.500 Care & services ************************************	Connexus Gold 1000		
beductible per formily \$1.000 \$3.000 beductible per formily \$2,000 \$6,000 Dut- of-pocket max per person \$6,750 \$20,250 Dut- of-pocket max per formily \$13,500 \$40,500 Care & services ************************************		In-network member pays	Out-of-network member pays
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Dut-of-pocket max per person \$6,750 \$20,250 Dut-of-pocket max per family \$13,500 \$40,500 Care & services ************************************	Deductible per person	\$1,000	\$3,000
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Preventive care visit \$0\/visit \$0\% after deductible Primary care provider (PCP) visit \$\$30\/visit \$0\% after deductible Spacialist visit \$\$80\/visit \$0\% after deductible Jrigent care visit \$\$20\/visit \$0\% after deductible Jrigent care visit \$\$20\/visit \$0\% after deductible Dutp after deductible \$\$0\% after deductible \$\$0\% after deductible Dutp after deductible \$\$0\% after deductible \$\$0\% after deductible Dutp after deductible \$\$0\% after deductible \$\$0\% after deductible Dutp after deductible \$\$0\% after deductible \$\$0\% after deductible Dutp after deductible \$\$0\% after deductible \$\$0\% after deductible Dutp after deductible \$\$0\% after deductible \$\$0\% after deductible Dutp after deductible \$\$0\% after deductible \$\$0\% after deductible Dutp after deductible \$\$0\% after deductible \$\$0\% after deductible Preserviption medications' \$\$0\% after deductible \$\$0\% after deductible Preserviption medications' \$\$0\% after deductible \$\$0\% after deductible Pres	Out-of-pocket max per family	\$13,500	\$40,500
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urgent care visit \$30/visit 50% ofter deductible virtual care visit \$20/visit 50% ofter deductible Dutpatient diagnostic X-ray & lab 25% 50% ofter deductible Emergency room visit \$300/25%/visit \$300/25%/visit Ambulance 25% after deductible 25% after deductible patient/outpatient care 25% after deductible 50% ofter deductible Dutpatient mental health/chemical dependency visit \$30/visit 50% ofter deductible Physical, speech or occupational therapy visit \$60/visit 50% ofter deductible Velupuncture and spinal manipulation services \$30/visit 50% ofter deductible Velupuncture and spinal manipulation services \$30/visit 50% ofter deductible Value \$2 \$2 \$2 Value \$2 \$2 \$2 Select \$10 \$10 \$10 Veferred \$50% \$0% \$0% Veferred Specialty \$50% \$0% \$2% Veferred Specialty \$50% \$0 \$0 Veferred Specialty	Primary care provider (PCP) visit	\$30/visit	50% after deductible
Virtual care visit \$20/visit 50% after deductible Dutpatient diagnostic X-roy & lab 25% 50% after deductible Emergency room visit \$300/25%/visit \$300/25%/visit Ambulance 25% after deductible 25% after deductible Dutpatient/outpatient care 25% after deductible 50% after deductible Dutpatient mental health/chemical dependency visit \$300/visit 50% after deductible Physical, speech or occupational therapy visit \$60/visit 50% after deductible Veryuncture and spinal manipulation services \$30/visit 50% after deductible Predictric vision exam \$30/visit 50% after deductible Predictric vision hardware \$25% 50% after deductible Predictric vision hardware \$25% 50% after deductible Value \$2 \$2 Value \$2 \$2 Select \$10 \$10 Preferred \$20% \$0% Von -Preferred \$20% \$0% Preferred Specialty \$0% \$0% Von covered \$0%	Specialist visit	\$60/visit	50% after deductible
Dutpatient diagnostic X-ray & lab 25% 50% after deductible Emergency room visit \$300/25%/visit \$300/25%/visit Ambulance 25% after deductible 25% after deductible patient/outpatient care 25% after deductible 50% after deductible Dutpatient/outpatient care 25% after deductible 50% after deductible Dutpatient/outpatient care 25% after deductible 50% after deductible Dutpatient/outpatient care 50% after deductible 50% after deductible Dutpatient mental health/chemical dependency visit \$0% after deductible 50% after deductible Physical, speech or occupational therapy visit \$0% after deductible 50% after deductible Pediatric vision exam \$30/visit 50% after deductible Pediatric vision hardware 25% 50% after deductible Prescription medications' \$2 \$2 Value \$2 \$2 Preferred \$20% \$0% Non-Preferred \$0% \$0% Preferred Specialty \$0% Not covered Small business health care tax credit eligible <	Urgent care visit	\$30/visit	50% after deductible
Emergency room visit \$300/25%/visit \$300/25%/visit Ambulance 25% after deductible 25% after deductible patient/outpatient care 25% after deductible 50% after deductible Dutpatient/outpatient care 25% after deductible 50% after deductible Dutpatient/outpatient care 25% after deductible 50% after deductible Dutpatient mental health/chemical dependency visit \$60/visit 50% after deductible Physical, speech or occupational therapy visit \$60/visit 50% after deductible Pediatric vision exam \$330/visit 50% after deductible Pediatric vision hardware 25% 50% after deductible Prescription medications'	Virtual care visit	\$20/visit	50% after deductible
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Dutpatient mental health/chemical dependency visit \$30/visit 50% after deductible Physical, speech or occupational therapy visit \$60/visit 50% after deductible Accupancture and spinal manipulation services \$30/visit 50% after deductible Pediatric vision exam \$30/visit 50% after deductible Pediatric vision hardware 25% 50% after deductible Prescription medications1 50% after deductible 50% after deductible Value \$2 \$2 Value \$2 \$2 Value \$10 \$10 Preferred \$0% \$0% Non-Preferred Specialty 50% \$0% Vertered \$20% \$0 Preferred Specialty \$0% \$0% Small business health care tax credit eligible No \$0% Metallic level Yes \$0 Small business health care tax credit eligible Yes \$0 Metallic level Yes Yes \$0 Small business health care tax credit eligible Yes Yes Yes	Ambulance	25% after deductible	25% after deductible
Physical, speech or occupational therapy visit \$60/visit 50% after deductible Accupuncture and spinal manipulation services \$30/visit 50% after deductible Pediatric vision exam \$30/visit 50% after deductible Pediatric vision hardware 25% 50% after deductible Prescription medications' 25% 50% after deductible /alue \$2 \$2 /alue \$10 \$10 Preferred \$10 \$10 Preferred Specialty \$25% Not covered Von-Preferred Specialty 50% after deductible \$2 Features \$10 \$10 Metallic level 50% \$0% \$2 Small business health care tax credit eligible No \$2 \$2 Metalicare Part D creditable Yes \$2 \$2 \$2 Vetwork Connexus Network \$2 \$2 \$2 \$2 \$2 \$2 \$2 \$2 \$2 \$2 \$2 \$2 \$2 \$2 \$2 \$2 <t< td=""><td>npatient/outpatient care</td><td>25% after deductible</td><td>50% after deductible</td></t<>	npatient/outpatient care	25% after deductible	50% after deductible
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Pediatric vision hardware 25% 50% after deductible Prescription medications' 2 /alue \$2 \$2 /alue \$10 \$10 Select \$10 \$10 Preferred \$400 \$40 Non-Preferred 50% 50% Preferred Specialty \$20 \$2 Non-Preferred Specialty \$10 \$10 Preferred Specialty \$20% \$20% Non-Preferred Specialty \$0% \$10 Vetallic level \$0% \$0% Small business health care tax credit eligible No \$0% Metalic level Yes \$0% Network Connexus Network Yes	Acupuncture and spinal manipulation services	\$30/visit	50% after deductible
Prescription medications1 Image: space	Pediatric vision exam	\$30/visit	50% after deductible
/// Alue \$2 \$2 Select \$10 \$10 Preferred \$40 \$40 Non-Preferred \$0% \$0% Preferred Specialty \$0% \$0% Non-Preferred Specialty \$0% \$0% Non-Preferred Specialty \$0% Not covered Features \$0% Not covered Metallic level \$0% Not covered Small business health care tax credit eligible No \$0% Metallic level \$0% Yes Not covered Yes Yes Network Connexus Network Travel network First Health Network	Pediatric vision hardware	25%	50% after deductible
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Non-Preferred Specialty 50% Not covered Features Metallic level Gold Small business health care tax credit eligible No Metalicare Part D creditable Yes Network Connexus Network Travel network First Health Network	Non-Preferred	50%	50%
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Medicare Part D creditable Yes Network Connexus Network Travel network First Health Network	Metallic level	Gold	
Network Connexus Network Travel network First Health Network	Small business health care tax credit eligible	No	
First Health Network	Medicare Part D creditable	Yes	
	Network	Connexus Network	
Service area Statewide	Travel network	First Health Network	
	Service area	Statewide	

Limitations

- Acupuncture and spinal manipulation is subject to \$2,000 annual maximum
- Ambulance transportation is limited to six trips per calendar year
- Authorization by Moda Health is required for all medical and surgical admissions and some outpatient services and medications
- Biofeedback is limited to 10 visits per lifetime for tension or migraine headaches or urinary incontinence
- Brand tier medications If members use a brand medication when a generic equivalent is available, they will have to pay the nonpreferred cost sharing plus the difference in cost between the generic and brand medication
- 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 are covered once every three years
- Hospice respite care is limited to 30 days lifetime maximum and up to five days consecutive
- If a group's size is less than 20 employees any expense that is actually paid under Medicare, or would have paid under Medicare Part B had the member enrolled in Medicare, will have benefits reduced by the amount Medicare paid or would have paid.
- Infusion therapy some medications require use of an authorized provider to be eligible for coverage. Outpatient hospital setting is not covered for some medications.
- Prescriptions are limited to a maximum 30-day supply for standard retail and most specialty pharmacy and 90-day supply for mail order and participating retail pharmacies.
- Preventive services that are not required under the Affordable Care Act may have member cost sharing. Only women's exam, Pap test, mammogram, prostate exam and PSA test are covered out-of-network.
- Rehabilitation and habilitation benefits are 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 is limited to 60 days per year
- Transplants must be performed at a Center of Excellence to be eligible for coverage
- Vision exam and glasses or contacts are covered once per year for members under age 19

Exclusions

- 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, 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 ordered or provided by the patient or a member of the patient's immediate family
- 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 contract 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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