2023 Medical plan benefit summary

Moda Health Beacon Silver 6400 – CSV1

	In network you pay	Out-of-network you pay
Calendar year costs		
Deductible per person	$2,500	Not covered
Deductible per family	$5,000	Not covered
Out-of-pocket max per person	$6,400	Not covered
Out-of-pocket max per family	$12,800	Not covered
Care & services		
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	$70/visit	Not covered
Virtual care visit	$10/visit	Not covered
Outpatient diagnostic X-ray & lab	35% after deductible	Not covered
Emergency room visit	35% after deductible	35% after deductible
Ambulance	35% after deductible	35% after deductible
Inpatient/outpatient Care	35% after deductible	Not covered
Outpatient mental health/ substance use disorder visit	$35/visit	Not covered
Physical, speech or occupational therapy visit	$70/visit	Not covered
Acupuncture and spinal manipulation services	$35/visit	Not covered
Pediatric dental	Not covered	Not covered
Pediatric vision exam	$35/visit	Not covered
Pediatric vision hardware	35% after deductible	Not covered
Prescription medications[1]		
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
Features		
Metallic level	Silver	
Exchange	On	
Provider network	Beacon	
Travel network	Aetna PPO	
Service area	Clackamas, Clatsop, Columbia, Coos, Curry, Hood River, Jackson, Josephine, Multnomah, Tillamook, Wasco, Washington and Yamhill counties	

1 *One copay per 30-day supply. $80 maximum per 30-day supply for insulin*

Limitations

- Acupuncture: 12 visits per year
- Authorization by Moda Health is required for all medical and surgical admissions and some outpatient services and medications
- Biofeedback: Only for tension or migraine headaches or urinary incontinence. 10 visits per lifetime
- Brand tier medications: If you use a brand medication when a generic equivalent is available, you will have to pay the nonpreferred cost sharing plus the difference in cost between the generic and brand medication.
- Coordination of benefits: When 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: Once every 3 years. Hearing tests: Twice per year under age 4 and once per year age 4 and older
- Hospice respite care: 30 days per lifetime, up to five days in a row
- Infusion therapy: For some medications you must use an authorized provider. Outpatient hospital setting may not be covered
- Medicare: Any expense that is 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: 30-day supply for standard retail and most specialty pharmacy. 90-day supply for mail order and participating retail
- Preventive care: Cost sharing may apply to services not required under the Affordable Care Act. Only women's exam, Pap test, mammogram, prostate exam and PSA test are covered out-of-network
- Rehabilitation and habilitation: 30 inpatient days and 30 outpatient sessions per calendar year. Extra rehabilitation up to 60 days after acute head or spinal cord injury or 60 sessions to treat neurologic conditions. Separate limits for rehabilitative and habilitative services.
- Skilled nursing facility: 60 days per year
- Spinal manipulation: 20 visits per year
- Transplants must be performed at the authorized transplant facility to be eligible for coverage
- Vision exam and glasses or contacts: Once per year for members under age 19

Exclusions

- Care outside the United States, other than emergency care
- Charges over the maximum plan allowance
- Correctional services, including sheltered living and court-ordered anger management or sex offender treatment
- Cosmetic services and supplies (exception for reconstructive surgery if medically necessary and not specifically excluded)
- Custodial care
- Dental examinations and treatment except for accidental injury
- Experimental or investigational treatment
- Infertility (services or supplies to treat infertility, including reversal of sterilization)
- Injury you get from practicing for or participating in professional athletic activities
- Instruction programs, except under the outpatient diabetic instruction benefit
- Massage or massage therapy
- Naturopathic supplies. Includes 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
- Self-treatment. Services you provide to yourself or services from a member of your immediate family (other than a dental provider)
- Services or supplies available under any city, county, state or federal law, except Medicaid
- Temporomandibular Joint Syndrome (TMJ)
- Vision surgery to cure or reduce near-sightedness, far-sightedness or astigmatism

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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