



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE:** Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. **This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, contact Moda Health at www.modahealth.com or by calling 1-844-274-9117. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 1-844-274-9117 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$0	See the Common Medical Events chart below for your costs and services this plan covers.
Are there services covered before you meet your deductible ?	Yes. All services are covered before you meet your deductible .	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan ?	Not Applicable	This plan does not have an out-of-pocket limit on your expenses.
What is not included in the out-of-pocket limit ?	Not Applicable	This plan does not have an out-of-pocket limit on your expenses.
Will you pay less if you use a network provider ?	Yes. See www.modahealth.com or call 1-844-274-9117 for a list of network providers .	This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist ?	No.	You can see the specialist you choose without a referral .



All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP In-Network Provider (You will pay more)	Non-IHCP Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge	No charge	No charge	None
	Specialist visit	No charge	No charge	No charge	Office visits by naturopaths, acupuncturists and chiropractors are specialist visits. Preauthorization may be required to avoid a penalty of 50% up to a maximum deduction of \$2,500.
	Preventive care/screening /immunization	No charge	No charge	No charge	You may have to pay for services that aren't preventive . Ask your provider if the services needed are preventive . Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	No charge	No charge	Includes other tests such as EKG, allergy testing and sleep study.
	Imaging (CT/PET scans, MRIs)	No charge	No charge	No charge	Preauthorization may be required to avoid a penalty of 50% up to a maximum deduction of \$2,500.

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If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.modahealth.com/pdl	Value tier	No charge	No charge	No charge	Preauthorization may be required. Covers up to a 90-day supply for retail and mail order prescriptions.
	Select tier	No charge	No charge	No charge	
	Preferred tier	No charge	No charge	No charge	
	Non-preferred tier	No charge	No charge	No charge	
	Specialty drug tier	No charge	No charge	Not covered	One copay for each 30-day supply Mail order at a Moda Health designated mail order pharmacy only. Covers up to a 30-day supply for most specialty medications. Moda Health designated specialty pharmacy only. Anticancer medication is covered at No charge
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	No charge	No charge	Preauthorization may be required to avoid a penalty of 50% up to a maximum deduction of \$2,500.
	Physician/surgeon fees	No charge	No charge	No charge	
If you need immediate medical attention	Emergency room care	No charge	No charge	No charge	None
	Emergency medical transportation	No charge	No charge	No charge	Commercial transportation is limited to one-way for a sudden, life-endangering medical condition.
	Urgent care	No charge	No charge	No charge	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	No charge	No charge	Preauthorization may be required to avoid a penalty of 50% up to a maximum deduction of \$2,500.
	Physician/surgeon fees	No charge	No charge	No charge	

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		Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP In-Network Provider (You will pay more)	Non-IHCP Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	No charge	No charge	Psychological or neuropsychological testing limited to 12 hours per calendar year. Preauthorization may be required to avoid a penalty of 50% up to a maximum deduction of \$2,500.
	Inpatient services	No charge	No charge	No charge	Preauthorization may be required to avoid a penalty of 50% up to a maximum deduction of \$2,500.
If you are pregnant	Office visits	No charge	No charge	No charge	Cost sharing does not apply for preventive services . Depending on the type of services, a copay , coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	No charge	No charge	No charge	
	Childbirth/delivery facility services	No charge	No charge	No charge	
If you need help recovering or have other special health needs	Home health care	No charge	No charge	No charge	Limited to 130 visits per year.
	Rehabilitation services	No charge	No charge	No charge	Calendar Year maximum of 30 inpatient days for rehabilitation and 45 outpatient sessions for rehabilitation and habilitation. Limits apply separately to outpatient rehabilitative and habilitative services. Preauthorization may be required to avoid a penalty of 50% up to a maximum deduction of \$2,500.
	Habilitation services	No charge for outpatient. Not covered for inpatient.	No charge for outpatient. Not covered for inpatient.	No charge for outpatient. Not covered for inpatient.	
	Skilled nursing care	No charge	No charge	No charge	
	Durable medical equipment	No charge	No charge	No charge	Includes supplies and prosthetics. Frequency limits apply to some durable medical equipment (DME). Preauthorization may be required to avoid a penalty of 50% up to a maximum deduction of \$2,500.
	Hospice services	No charge	No charge	No charge	Lifetime maximum of 10 inpatient days and 240 hours respite care.

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		Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP In-Network Provider (You will pay more)	Non-IHCP Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	No charge	No charge	No charge	Limited to 1 per year.
	Children's glasses	No charge	No charge	No charge	Coverage limited to 1 pair of glasses with frames from the Otis & Piper Eyewear collection per year for children under age 19. For age 19 and over, see member handbook for vision cost sharing and limits.
	Children's dental check-up	No charge	No charge	No charge	For members under age 19. Frequency limits and Plan coinsurance may apply to some services.

Excluded Services & Other Covered Services:

Services Your [Plan](#) Generally Does NOT Cover (Check your policy or [plan](#) document for more information and a list of any other [excluded services](#).)

- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Naturopathic supplies
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- Acupuncture, limited to 24 visits per calendar year
- Chiropractic care, limited to 24 visits per calendar year
- Hearing aids, limited to one per ear every 3 years
- Routine eye care (Adult), limited to one eye exam per year

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or <http://www.dol.gov/ebsa/healthreform> for group health coverage subject to ERISA, the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov for non-federal governmental group health plans, the Alaska Division of Insurance at 1-800-467-8725 or <http://www.commerce.state.ak.us/ins/Insurance/consumer.html> for Church plans. Other coverage options may be available to you, too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information on how to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: Moda Health at 1-888-873-1395 or the Alaska Division of Insurance at <http://www.commerce.state.ak.us/ins/Insurance/consumer.html> or 1-800-

467-8725. For group health coverage subject to ERISA, you may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

Does this plan meet the Minimum Value Standards? Yes

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 888-786-7461.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 888-873-1395.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 888-873-1395.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 888-873-1395.

To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost-sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The plan's overall deductible	\$0
■ Specialist coinsurance	0%
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	0%

This EXAMPLE event includes services like:

[Specialist](#) office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
[Diagnostic tests](#) (*ultrasounds and blood work*)
[Specialist](#) visit (*anesthesia*)

Total Example Cost	\$12,700
In this example, Peg would pay:	
<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$0*
Coinsurance	\$0*
<i>What isn't covered</i>	
Limits or exclusions	\$50
The total Peg would pay is	\$50*

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$0
■ Specialist coinsurance	0%
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	0%

This EXAMPLE event includes services like:

[Primary care physician](#) office visits (*including disease education*)
[Diagnostic tests](#) (*blood work*)
[Prescription drugs](#)
[Durable medical equipment](#) (*glucose meter*)

Total Example Cost	\$5,600
In this example, Joe would pay:	
<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$20

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall deductible	\$0
■ Specialist coinsurance	0%
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	0%

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)
[Diagnostic test](#) (*x-ray*)
[Durable medical equipment](#) (*crutches*)
[Rehabilitation services](#) (*physical therapy*)

Total Example Cost	\$2,800
In this example, Mia would pay:	
<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$0

*Note: These numbers assume a global charge. If your provider bills each service separately, these amounts may be different.

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.