



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 ?	For network providers \$3,500 individual / \$7,000 family; Out-of-network providers \$10,500 individual / \$21,000 family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit ?	Premiums , balance-billing charges, expenses incurred due to brand substitution, preauthorization penalties and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Will you pay less if you use a network provider ?	Yes. See https://www.modahealth.com/ProviderSearch?productCategory=medical&selectedNetwork=Moda%20Select 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
		Network Provider (You will pay the least)	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	\$0 copay /visit	60% coinsurance	None
	Specialist visit	\$0 copay /acupuncture, massage therapy, spinal manipulation, virtual care and CirrusMD virtual visit, \$10 copay /office visit	60% coinsurance	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 for most services, 25% coinsurance for remaining services.	60% coinsurance	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)	25% coinsurance	60% coinsurance	Includes other tests such as EKG, allergy testing and sleep study.
	Imaging (CT/PET scans, MRIs)	25% coinsurance	60% coinsurance	Preauthorization may be required to avoid a penalty of 50% up to a maximum deduction of \$2,500.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
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	Preauthorization may be required. Covers up to a 90-day supply for retail and mail order prescriptions. 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 \$150 copay or 25% coinsurance , whichever is less
	Select tier	No charge	No charge	
	Preferred tier	\$15 copay /retail prescription, \$45 copay /90-day retail and mail order prescription	\$15 copay /prescription	
	Non-preferred tier	\$50 copay /retail prescription, \$150 copay /90-day retail and mail order prescription	\$50 copay /prescription	
	Specialty drug tier	\$150 copay /prescription	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% coinsurance	60% coinsurance	Preauthorization may be required to avoid a penalty of 50% up to a maximum deduction of \$2,500.
	Physician/surgeon fees	25% coinsurance	60% coinsurance	
If you need immediate medical attention	Emergency room care	25% coinsurance	25% coinsurance	In-network out-of-pocket limit applies
	Emergency medical transportation	25% coinsurance	25% coinsurance	Commercial transportation is limited to one-way for a sudden, life-endangering medical condition. In-network out-of-pocket limit applies
	Urgent care	\$5 copay /office visit, \$0 copay /virtual care and CirrusMD virtual visit	60% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	25% coinsurance	60% coinsurance	Preauthorization may be required to avoid a penalty of 50% up to a maximum deduction of \$2,500.
	Physician/surgeon fees	25% coinsurance	60% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$0 copay /office and intensive outpatient, virtual care and CirrusMD virtual visit, 25% coinsurance for other outpatient services	60% coinsurance	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	25% coinsurance	60% coinsurance	Preauthorization may be required to avoid a penalty of 50% up to a maximum deduction of \$2,500.
If you are pregnant	Office visits	\$10 copay /visit	60% coinsurance	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	25% coinsurance	60% coinsurance	
	Childbirth/delivery facility services	25% coinsurance	60% coinsurance	
If you need help recovering or have other special health needs	Home health care	25% coinsurance	60% coinsurance	Limited to 130 visits per year.
	Rehabilitation services	\$0 copay /outpatient visit 25% coinsurance for inpatient	60% coinsurance	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.
	Habilitation services	\$0 copay /outpatient visit. Not covered for inpatient.	60% coinsurance for outpatient, not covered for inpatient.	Preauthorization may be required to avoid a penalty of 50% up to a maximum deduction of \$2,500.
	Skilled nursing care	25% coinsurance	60% coinsurance	Limited to 60 days per calendar year.
	Durable medical equipment	25% coinsurance 20% coinsurance for hearing aids	60% coinsurance 20% coinsurance for hearing aids	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	25% coinsurance	60% coinsurance	Lifetime maximum of 10 inpatient days and 240 hours respite care.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	No charge	50% coinsurance	Limited to 1 per year.
	Children's glasses	No charge	50% coinsurance	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	60% coinsurance	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-

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.modahealth.com.

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 copayment	\$10
■ Hospital (facility)	25%
■ Other coinsurance	25%

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
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$0*
Coinsurance	\$3,100*
What isn't covered	
Limits or exclusions	\$50
The total Peg would pay is	\$3,150*

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 copayment	\$10
■ Hospital (facility)	25%
■ Other coinsurance	25%

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
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$600
Coinsurance	\$90
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$710

Mia's Simple Fracture

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

■ The plan's overall deductible	\$0
■ Specialist copayment	\$10
■ Hospital (facility)	25%
■ Other coinsurance	25%

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
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$30
Coinsurance	\$600
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$630

*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.