



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/texas or by calling 1-844-827-6571. 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 1-844-827-6571 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For network providers \$1,000 individual / \$2,000 family. Out-of-network providers are not covered.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible .
Are there services covered before you meet your deductible?	Yes. In-network preventive care , primary care, specialist , urgent care , virtual visits, outpatient behavioral health services, outpatient rehabilitation and habilitation, adult eye exams, children's vision services, as well as most in and out of network prescription medications 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 \$10,000 individual / \$20,000 family. Out-of-network providers are not covered.	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&state=TX or call 1-844-827-6571 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	\$15 copay /office visit, \$5 copay /virtual care visit, No charge/CirrusMD virtual visit; deductible does not apply	Not covered	None
	Specialist visit	\$30 copay /office visit, \$5 copay /virtual care visit, No charge/CirrusMD virtual visit; deductible does not apply	Not covered	None
	Preventive care/screening /immunization	No charge for most services. \$15 copay /visit, deductible does not apply or 15% coinsurance for remaining services.	Not covered	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)	15% coinsurance	Not covered	Includes other tests such as EKG, allergy testing and sleep study. Preauthorization may be required. Failure to get preauthorization results in denial.
	Imaging (CT/PET scans, MRIs)	15% coinsurance	Not covered	Preauthorization may be required. Failure to get preauthorization results in denial.

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 https://www.modahealth.com/texas/-/media/Texas/Downloads/Shared/Documents/ModaHealth-Texas-Individual-Plans-Formulary.pdf	Value drug tier	\$2 copay /retail prescription, \$6 copay /90-day retail and mail order prescription; deductible does not apply	\$2 copay /retail prescription, deductible does not apply	Preauthorization may be required. Covers up to a 30-day supply (retail pharmacy) and 90-day supply (mail order and participating retail pharmacies). 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. Moda Health designated pharmacy only. Cost sharing for anticancer medication is 15% coinsurance . Maximum cost sharing for insulin per 30-day prescription fill is \$25.
	Generic drugs (Select tier)	\$10 copay /retail prescription, \$30 copay /90-day retail and mail order prescription; deductible does not apply	\$10 copay /retail prescription, deductible does not apply	
	Preferred brand drug tier	40% coinsurance , deductible does not apply	40% coinsurance , deductible does not apply	
	Non-preferred brand drug tier	50% coinsurance , deductible does not apply	50% coinsurance , deductible does not apply	
	Specialty drug tier	45% coinsurance for preferred, 50% coinsurance for non-preferred; deductible does not apply	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% coinsurance	Not covered	Preauthorization may be required. Failure to get preauthorization results in denial.
	Physician/surgeon fees	15% coinsurance	Not covered	
If you need immediate medical attention	Emergency room care	40% coinsurance	40% coinsurance in-network deductible applies	None
	Emergency medical transportation	15% coinsurance	15% coinsurance in-network deductible applies	None
	Urgent care	\$30 copay /office visit, \$5 copay /virtual care visit, No charge/CirrusMD virtual visit; deductible does not apply	Not covered	None

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 have a hospital stay	Facility fee (e.g., hospital room)	15% coinsurance	Not covered	Preauthorization may be required. Failure to get preauthorization results in denial.
	Physician/surgeon fees	15% coinsurance	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$15 copay /office visit and intensive outpatient visits, \$5 copay /virtual care visit, No charge/CirrusMD virtual visit; deductible does not apply. 15% coinsurance for other outpatient services	Not covered	Preauthorization may be required. Failure to get preauthorization results in denial.
	Inpatient services	15% coinsurance	Not covered	Preauthorization may be required. Failure to get preauthorization results in denial.
If you are pregnant	Office visits	No charge	Not covered	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	15% coinsurance	Not covered	
	Childbirth/delivery facility services	15% coinsurance	Not covered	
If you need help recovering or have other special health needs	Home health care	15% coinsurance	Not covered	Limited to 60 visits per calendar year.
	Rehabilitation services	\$30 copay /outpatient visit, deductible does not apply. 15% coinsurance for inpatient	Not covered	Calendar year maximum of 35 outpatient sessions. Limits apply separately to rehabilitation and habilitation. Preauthorization may be required. Failure to get preauthorization results in denial.
	Habilitation services	\$30 copay /outpatient visit, deductible does not apply. 15% coinsurance for inpatient	Not covered	
	Skilled nursing care	15% coinsurance	Not covered	Limited to 25 days per calendar year.

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 help recovering or have other special health needs	Durable medical equipment	15% coinsurance	Not covered	Includes supplies and prosthetics. Frequency limits apply to some durable medical equipment (DME). Preauthorization may be required. Failure to get preauthorization results in denial.
	Hospice services	15% coinsurance	Not covered	Preauthorization may be required. Failure to get preauthorization results in denial.
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	Limited to one eye exam per calendar year for children under age 19. Additional in-network preventive eye screening for children age 3-5 at no cost sharing .
	Children's glasses	No charge	Not covered	Coverage limited to one pair of glasses per calendar year for children under age 19.
	Children's dental check-up	Not covered	Not covered	None

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 .)			
- Abortion (except in the case of a medical emergency of a pregnant woman) - Acupuncture - Bariatric surgery - Children's dental check-up	- Cosmetic surgery (except as required for certain situations) - 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.)		
Chiropractic care, limited to 35 sessions per year, combined with physical, occupational, and speech therapies	Hearing aids, limited to one hearing aid per ear every three 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/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa>, Texas Department of Insurance, 1-800-578-4677 or <http://www.tdi.texas.gov>, or contact Moda Health at 1-844-827-6571. 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 1-844-827-6571 or Texas Department of Insurance at <http://www.tdi.texas.gov>.

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? Not Applicable.

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 844-827-6571.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 844-827-6571.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 844-827-6571.

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	\$1,000
■ Specialist copayment	\$30
■ Hospital (facility) coinsurance	15%
■ Other coinsurance	15%

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:

<i>Cost Sharing</i>	
Deductibles	\$1,000
Copayments	\$10*
Coinsurance	\$1,700*

<i>What isn't covered</i>	
Limits or exclusions	\$50

The total Peg would pay is	\$2,760*
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Managing Joe's Type 2 Diabetes

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

■ The plan's overall deductible	\$1,000
■ Specialist copayment	\$30
■ Hospital (facility) coinsurance	15%
■ Other coinsurance	15%

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:

<i>Cost Sharing</i>	
Deductibles	\$400
Copayments	\$200
Coinsurance	\$1,700

<i>What isn't covered</i>	
Limits or exclusions	\$20

The total Joe would pay is	\$2,320
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Mia's Simple Fracture

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

■ The plan's overall deductible	\$1,000
■ Specialist copayment	\$30
■ Hospital (facility) coinsurance	15%
■ Other coinsurance	15%

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:

<i>Cost Sharing</i>	
Deductibles	\$1,000
Copayments	\$100
Coinsurance	\$400

<i>What isn't covered</i>	
Limits or exclusions	\$0

The total Mia would pay is	\$1,500
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*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.