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 1-888-873-1395. 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 1-888-873-1395 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For network providers $5,950 individual / $11,900 family; Out-of-network providers $11,900 individual / $23,800 family.	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. For example: most preventive care, in and out-of-network Value tier prescription medications, in and out-of-network children's routine eye exams and glasses, 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 $8,700 individual / $17,400 family; Out-of-network providers $45,000 individual / $90,000 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 1-888-873-1395 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.

Important Questions	Answers	Why This Matters:
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	40% coinsurance for office and virtual care visit, 0% coinsurance for CirrusMD virtual visit	50% coinsurance	None
	Specialist visit	40% coinsurance for acupuncture, massage therapy, spinal manipulation, office and virtual care visit, 0% coinsurance for CirrusMD virtual visit	50% 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. 40% coinsurance for remaining services.	50% 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)	40% coinsurance	50% coinsurance	Includes other tests such as EKG, allergy testing and sleep study.
	Imaging (CT/PET scans, MRIs)	40% coinsurance	50% coinsurance	Preauthorization may be required to avoid a penalty of 50% up to a maximum deduction of $2,500.

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

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. 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 40% coinsurance
	Select tier	40% coinsurance	40% coinsurance	
	Preferred tier	40% coinsurance	40% coinsurance	
	Non-preferred tier	50% coinsurance	50% coinsurance	
	Specialty drug tier	45% coinsurance preferred specialty prescription. 50% coinsurance non-preferred specialty prescription.	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% coinsurance	50% coinsurance	Preauthorization may be required to avoid a penalty of 50% up to a maximum deduction of $2,500.
	Physician/surgeon fees	40% coinsurance	50% coinsurance	
If you need immediate medical attention	Emergency room care	40% coinsurance	40% coinsurance	In-network deductible and out-of-pocket limit apply.
	Emergency medical transportation	40% coinsurance	40% coinsurance	Commercial transportation is limited to one-way for a sudden, life-endangering medical condition. In-network deductible and out-of-pocket limit apply.
	Urgent care	40% coinsurance for office and virtual care visit, 0% coinsurance for CirrusMD virtual visit	50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	40% coinsurance	50% coinsurance	Preauthorization may be required to avoid a penalty of 50% up to a maximum deduction of $2,500.
	Physician/surgeon fees	40% coinsurance	50% coinsurance	

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

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	40% coinsurance for office and intensive outpatient, virtual care and other outpatient services, 0% coinsurance for CirrusMD virtual visit	50% 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	40% coinsurance	50% 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	No charge	50% 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	40% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	40% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	40% coinsurance	50% coinsurance	Limited to 130 visits per year.
	Rehabilitation services	40% coinsurance	50% 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. Preauthorization may be required to avoid a penalty of 50% up to a maximum deduction of $2,500.
	Habilitation services	40% coinsurance for outpatient, not covered for inpatient.	50% coinsurance for outpatient, not covered for inpatient.	
	Skilled nursing care	40% coinsurance	50% coinsurance	Limited to 60 days per calendar year.
	Durable medical equipment	40% coinsurance 20% coinsurance for hearing aids	50% 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	40% coinsurance	50% coinsurance	Lifetime maximum of 10 inpatient days and 240 hours respite care.

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

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, deductible does not apply.	Limited to 1 per calendar year for children under age 19.
	Children's glasses	No charge	50% coinsurance, deductible does not apply.	Coverage limited to 1 pair of glasses per calendar year for children under age 19.
	Children's dental check-up	0% coinsurance	50% 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 eye care (Adult)
- 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.)

- Abortion
- Acupuncture, limited to 24 visit per year
- Chiropractic care, limited to 24 visits per calendar year
- Hearing aids, limited to one per ear every 3 years

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, kwiijigo 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** **$5,950**
- **Specialist coinsurance** **40%**
- **Hospital (facility) coinsurance** **40%**
- **Other coinsurance** **40%**

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:	
Cost Sharing	
Deductibles	$5,950
Copayments	$0*
Coinsurance	$2,700*
What isn't covered	
Limits or exclusions	$50
The total Peg would pay is	**$8,700***

Managing Joe's Type 2 Diabetes

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

- **The plan's overall deductible** **$5,950**
- **Specialist coinsurance** **40%**
- **Hospital (facility) coinsurance** **40%**
- **Other coinsurance** **40%**

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:	
Cost Sharing	
Deductibles	$5,300
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$5,320**

Mia's Simple Fracture

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

- **The plan's overall deductible** **$5,950**
- **Specialist coinsurance** **40%**
- **Hospital (facility) coinsurance** **40%**
- **Other coinsurance** **40%**

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:	
Cost Sharing	
Deductibles	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

**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.