



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 \$1,000 individual / \$2,000 family; Out-of-network providers \$4,000 individual / \$8,000 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: In-network office visits for primary care, specialist and urgent care , virtual care visits, most preventive care , office visits for outpatient behavioral health services, outpatient diagnostic tests , outpatient rehabilitation services , habilitation services , and children's dental check-up services, most in and out-of-network prescription medications, in and out-of-network children's routine eye exams and glasses, adult vision care services and hearing 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 \$8,100 individual / \$16,200 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 .

Important Questions	Answers	Why This Matters:
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.
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	\$5 copay /first 3 in person or virtual visits, then \$25 copay /office and virtual care visit, No charge for CirrusMD virtual visit; Deductible does not apply	50% coinsurance	First 3 visits combined with virtual care, mental health or substance use disorder office visits.
	Specialist visit	\$25 copay /acupuncture, massage therapy, spinal manipulation and virtual care visit, \$50 copay /office visit, No charge for CirrusMD virtual visit; Deductible does not apply	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. \$25 copay /visit, deductible does not apply or 20% 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)	20% coinsurance , deductible does not apply in outpatient/office setting.	50% coinsurance	Includes other tests such as EKG, allergy testing and sleep study.
	Imaging (CT/PET scans, MRIs)	20% 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. 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 20% coinsurance
	Select tier	\$20 copay /retail prescription, \$60 copay /90-day retail and mail order prescription; deductible does not apply	\$20 copay /prescription; deductible does not apply	
	Preferred tier	\$40 copay /retail prescription, \$120 copay /90-day retail and mail order prescription; deductible does not apply	\$40 copay /prescription; deductible does not apply	
	Non-preferred tier	\$100 copay /retail prescription, \$300 copay /90-day retail and mail order prescription; deductible does not apply	\$100 copay /prescription; deductible does not apply	
	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)	20% coinsurance	50% coinsurance	Preauthorization may be required to avoid a penalty of 50% up to a maximum deduction of \$2,500.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	
If you need immediate medical attention	Emergency room care	\$250 copay /visit, then deductible , 20% coinsurance	\$250 copay /visit, then deductible , 20% coinsurance	Copay waived if hospital admission immediately follows. In-network deductible and out-of-pocket limit apply.
	Emergency medical transportation	20% coinsurance	20% 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	\$50 copay /office visit, \$25 copay /virtual care visit, No charge for CirrusMD virtual visit; Deductible does not apply	50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	Preauthorization may be required to avoid a penalty of 50% up to a maximum deduction of \$2,500.
	Physician/surgeon fees	20% coinsurance	50% 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	\$5 copay /first 3 visits per year, then \$50 copay /office visits and intensive outpatient visits, deductible does not apply, \$25 copay /virtual care visit, deductible does not apply, No charge for CirrusMD virtual visit, 20% coinsurance for other outpatient services	50% coinsurance	First 3 visits combined with virtual care and PCP office visits. 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	20% 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	\$50 copay /visit, deductible does not apply.	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	20% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	50% 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 help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	Limited to 130 visits per year.
	Rehabilitation services	\$50 copay /outpatient visit, deductible does not apply. 20% coinsurance for inpatient	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	\$50 copay /outpatient visit, deductible does not apply. Not covered for inpatient.	50% coinsurance for outpatient, not covered for inpatient.	
	Skilled nursing care	20% coinsurance	50% coinsurance	Limited to 60 days per calendar year.
	Durable medical equipment	20% coinsurance 20% coinsurance for hearing aids, deductible does not apply.	50% coinsurance 20% coinsurance for hearing aids, deductible does not apply.	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	20% coinsurance	50% coinsurance	Lifetime maximum of 10 inpatient days and 240 hours respite care.
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.
	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. For age 19 and over, see member handbook for vision limits.
	Children's dental check-up	No charge	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 | • Long-term care | • Private-duty nursing |
| • Cosmetic surgery | • Naturopathic supplies | • Routine foot care |
| • Dental care (Adult) | • Non-emergency care when traveling outside the U.S. | • Weight loss programs |
| • Infertility treatment | | |

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

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|---|---|--|
| • Abortion | • Chiropractic care, limited to 24 visits per calendar year | • Routine eye care (Adult), limited to one eye exam per year |
| • Acupuncture, limited to 24 visit per 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 1-866-444-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	\$1,000
■ Specialist copayment	\$50
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

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	\$1,000
Copayments	\$10*
Coinsurance	\$2,300*
What isn't covered	
Limits or exclusions	\$50
The total Peg would pay is	\$3,360*

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	\$50
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

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	\$200
Copayments	\$1,300
Coinsurance	\$20
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$1,540

Mia's Simple Fracture

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

■ The plan's overall deductible	\$1,000
■ Specialist copayment	\$50
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

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	\$1,000
Copayments	\$400
Coinsurance	\$200
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,600

*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.