# Moda Health Plan, Inc.: Moda Health Providence Expedition 3500

**Coverage Period: 01/01/2016 – 12/31/2016**

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage for:** Individual + Family | **Plan Type:** PPO

**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **www.modahealth.com** or by calling **1-888-873-1395**. You can review your handbook at www.modahealth.com

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | In-network providers: **$3,500** per person / **$7,000** per family. Out-of-network providers: **$7,000** per person / **$14,000** per family. Doesn't apply to most in-network preventive care; routine nursery care; value drugs; or breastfeeding support. Copayments don't count toward the **deductible**. | You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**. |
| **Are there other deductibles for specific services?** | No. | You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers. |
| **Is there an out–of–pocket limit on my expenses?** | Yes. In-network providers: **$6,850** per person / **$13,700** per family. Out-of-network providers: **$13,700** per person / **$27,400** per family. | The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. |
| **What is not included in the out–of–pocket limit?** | Premiums, balance-billed charges, penalties for failure to obtain prior authorization and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the **out-of-pocket limit**. |
| **Is there an overall annual limit on what the plan pays?** | No. | The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits. |
| **Does this plan use a network of providers?** | Yes. See **www.modahealth.com or call 1-888-873-1395** for a list of participating providers. | If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**. |
| **Do I need a referral to see a specialist?** | No. | You can see the **specialist** you choose without permission from this plan. |
| **Are there services this plan doesn't cover?** | Yes. | Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**. |

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

| Common Medical Event | Services You May Need | Your Cost If You Use an In-network Provider | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | 50% coinsurance | 50% coinsurance | ——————none—————— |
| | Specialist visit | 50% coinsurance | 50% coinsurance | Includes office visits by alternative care providers. |
| | Other practitioner office visit | 50% coinsurance | 50% coinsurance | Spinal manipulation 12 visit per year limit; acupuncture 12 visit per year limit. Not applicable to office visits by other practitioners. |
| | Preventive care/screening / immunization | No charge for most services. 50% coinsurance for remaining services. | 50% coinsurance | Each type of service may be subject to limitations. In-network **deductible** waived for most services. A list of preventive health care benefits not subject to cost sharing can be viewed at http://www.healthcare.gov/what-are-my-preventive-care-benefits/ |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 50% coinsurance | 50% coinsurance | Include other tests such as EKG, allergy testing and sleep study. |
| | Imaging (CT/PET scans, MRIs) | 50% coinsurance | 50% coinsurance | Prior authorization may be required to avoid a penalty of 50% up to a maximum deduction of $2,500. |

| Common Medical Event | Services You May Need | Your Cost If You Use an In-network Provider | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you need drugs to treat your illness or condition**<br><br>More information about **prescription drug coverage** is available at www.modahealth.com/pdl | Value tier | $2 copay retail, $6 copay mail-order | $2 copay retail | Covers up to a 30-day supply (retail prescriptions); 90 day supply (mail-order prescription). Prior authorization may be required. Mail order at exclusive mail order pharmacy only. **Deductible** waived for value drugs. Anticancer medication is covered at the standard coinsurance rate for in-network and out-of-network providers. |
| | Select tier | 30% coinsurance | 30% coinsurance | |
| | Preferred tier | 35% coinsurance | 35% coinsurance | |
| | Brand tier | 45% coinsurance | 45% coinsurance | |
| | Specialty tier | 45% coinsurance | Not covered | Covers up to a 30-day supply. Prior authorization may be required. Exclusive pharmacy only. Anticancer medication is covered at the standard coinsurance rate for in-network and out-of-network providers. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 50% coinsurance | 50% coinsurance | Prior authorization may be required to avoid a penalty of 50% up to a maximum deduction of $2,500. |
| | Physician/surgeon fees | 50% coinsurance | 50% coinsurance | |
| **If you need immediate medical attention** | Emergency room services | $250 copay/visit, then 50% coinsurance | $250 copay/visit, then 50% coinsurance | Copay waived if hospital admission immediately follows. In-network **out-of-pocket** maximum applies to mental health and substance abuse services. |
| | Emergency medical transportation | 50% coinsurance | 50% coinsurance | Commercial transportation is limited to one-way for a sudden, life-endangering medical condition. |
| | Urgent care | 50% coinsurance | 50% coinsurance | ——————none—————— |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 50% coinsurance | 50% coinsurance | Prior authorization required to avoid a penalty of 50% up to a maximum deduction of $2,500. |
| | Physician/surgeon fee | 50% coinsurance | 50% coinsurance | |

| Common Medical Event | Services You May Need | Your Cost If You Use an In-network Provider | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you have mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | 50% coinsurance | 50% coinsurance | ——————none—————— |
| | Mental/Behavioral health inpatient services | 50% coinsurance | 50% coinsurance | Prior authorization is required for inpatient and residential services to avoid a penalty of 50% up to a maximum deduction of $2,500. |
| | Substance use disorder outpatient services | 50% coinsurance | 50% coinsurance | ——————none—————— |
| | Substance use disorder inpatient services | 50% coinsurance | 50% coinsurance | Prior authorization is required for inpatient and residential services to avoid a penalty of 50% up to a maximum deduction of $2,500. |
| **If you are pregnant** | Prenatal and postnatal care | 50% coinsurance | 50% coinsurance | Includes voluntary abortion services rendered by a licensed and certified professional provider. **Deductible** waived for routine nursery care and breastfeeding support. |
| | Delivery and all inpatient services | 50% coinsurance | 50% coinsurance | |
| **If you need help recovering or have other special health needs** | Home health care | 50% coinsurance | 50% coinsurance | Calendar year maximum of 130 visits. Prior authorization required to avoid a penalty of 50% up to a maximum deduction of $2,500. |
| | Rehabilitation services | 50% coinsurance | 50% coinsurance | Calendar year maximum of 30 days for inpatient and 45 sessions for outpatient rehabilitation and habilitation. |
| | Habilitation services | 50% coinsurance | 50% coinsurance | |
| | Skilled nursing facility care | 50% coinsurance | 50% coinsurance | Calendar year maximum of 60 days. |

| Common Medical Event | Services You May Need | Your Cost If You Use an In-network Provider | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you need help recovering or have other special health needs (continued)** | Durable medical equipment | 50% coinsurance | 50% coinsurance | Include items such as supplies and prosthetics. Wheelchairs subject to frequency limits. Prior authorization may be required to avoid a penalty of 50% up to a maximum deduction of $2,500. |
| | Hospice service | 50% coinsurance | 50% coinsurance | Calendar year maximum of 12 days for inpatient care and 170 hours for respite care. |
| **If your child needs dental or eye care** | Eye exam | 50% coinsurance | 50% coinsurance | In-network **deductible** waived. Preventive eye exam limited to in-network for children age 3-5. Eye exams are not covered for other ages. |
| | Glasses | 50% coinsurance | 50% coinsurance | Covers one pair of glasses per calendar year, under age 19. In-network **deductible** waived. |
| | Dental check-up | No charge | 50% coinsurance | For members under age 19. Frequency limits apply to some services. In-network **deductible** waived. |

## Excluded Services & Other Covered Services:

**Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Bariatric surgery
- Cosmetic surgery, except as required for certain situations
- Dental care (Adult) except for accident-related injuries
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care, with the exception for diabetes
- Weight loss programs

**Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Acupuncture
- Chiropractic care
- Hearing aids
- Routine eye care (Adult)

## Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-888-873-1395. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov

## Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact the insurer at 1-888-873-1395. 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. Additionally, a consumer assistance program can help you file your appeal. Contact the Alaska Insurance Division at 1-800-467-8725 or http://www.commerce.state.ak.us/insurance/Insurance/filingAComplaint.html A list of states with Consumer Assistance Programs is available at www.dol.gov/ebsa/healthreform and http://cciio.cms.gov/prgrams/consumer/capgrants/index.html.

## Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

## Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

## 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 page.*

## About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important **information about these examples.**

### Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $1,940
- **Patient pays** $5,600

**Sample care costs:**

| | |
|---|---|
| Hospital charges (mother) | $2,700 |
| Routine obstetric care | $2,100 |
| Hospital charges (baby) | $900 |
| Anesthesia | $900 |
| Laboratory tests | $500 |
| Prescriptions | $200 |
| Radiology | $200 |
| Vaccines, other preventive | $40 |
| **Total** | **$7,540** |

**Patient pays:**

| | |
|---|---|
| Deductibles | $3,500 |
| Copays | $0 |
| Coinsurance | $1,900 |
| Limits or exclusions | $200 |
| **Total** | **$5,600** |

### Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $2,650
- **Patient pays** $2,750

**Sample care costs:**

| | |
|---|---|
| Prescriptions | $2,900 |
| Medical Equipment and Supplies | $1,300 |
| Office Visits and Procedures | $700 |
| Education | $300 |
| Laboratory tests | $100 |
| Vaccines, other preventive | $100 |
| **Total** | **$5,400** |

**Patient pays:**

| | |
|---|---|
| Deductibles | $1,270 |
| Copays | $0 |
| Coinsurance | $1,400 |
| Limits or exclusions | $80 |
| **Total** | **$2,750** |

# Questions and answers about the Coverage Examples:

## What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

## What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

## Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

## Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

## Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

## Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.