



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](http://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](http://www.healthcare.gov/sbc-glossary) or call 1-844-827-6571 to request a copy.

| Important Questions                                                                   | Answers                                                                                                                                                                                                                                                                                                                                                                                                                  | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|---------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>What is the overall <a href="#">deductible</a>?</b>                                | For <a href="#">network providers</a> \$7,000 individual / \$14,000 family. <a href="#">Out-of-network providers</a> are not covered.                                                                                                                                                                                                                                                                                    | Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .                                                                                                                                                                                                            |
| <b>Are there services covered before you meet your <a href="#">deductible</a>?</b>    | Yes. In- <a href="#">network preventive care</a> , primary care, <a href="#">specialist</a> , <a href="#">urgent care</a> , 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 <a href="#">network</a> prescription medications are covered before you meet your <a href="#">deductible</a> . | This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .                                                                       |
| <b>Are there other <a href="#">deductibles</a> for specific services?</b>             | No.                                                                                                                                                                                                                                                                                                                                                                                                                      | You don't have to meet <a href="#">deductibles</a> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b> | For <a href="#">network providers</a> \$8,000 individual / \$16,000 family. <a href="#">Out-of-network providers</a> are not covered.                                                                                                                                                                                                                                                                                    | The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.                                                                                                                                                                                                                                                                                                                                                             |
| <b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>               | <a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, expenses incurred due to brand substitution, <a href="#">preauthorization</a> penalties and health care this <a href="#">plan</a> doesn't cover.                                                                                                                                                                                                     | Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Will you pay less if you use a <a href="#">network provider</a>?</b>               | Yes. See <a href="https://www.modahealth.com/ProviderSearch?productCategory=medical&amp;selectedNetwork=Moda%20Select&amp;state=TX">https://www.modahealth.com/ProviderSearch?productCategory=medical&amp;selectedNetwork=Moda%20Select&amp;state=TX</a> or call 1-844-827-6571 for a list of <a href="#">network providers</a> .                                                                                        | This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services. |

| Important Questions                                                          | Answers | Why This Matters:                                                                          |
|------------------------------------------------------------------------------|---------|--------------------------------------------------------------------------------------------|
| Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ? | No.     | You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> . |

 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<br>(You will pay the least)                                                                                                                                                                                                                                     | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                           |
| If you visit a health care <a href="#">provider's</a> office or clinic | Primary care visit to treat an injury or illness       | \$40 <a href="#">copay</a> /office visit,<br>\$30 <a href="#">copay</a> /virtual care visit,<br>No charge/CirrusMD virtual visit;<br><a href="#">deductible</a> does not apply                                                                                                   | Not covered                                        | None                                                                                                                                                                                      |
|                                                                        | <a href="#">Specialist</a> visit                       | \$70 <a href="#">copay</a> /office visit,<br>\$30 <a href="#">copay</a> /virtual care visit,<br>No charge/CirrusMD virtual visit,<br>\$10 <a href="#">copay</a> /adult eye exam,<br>\$45 <a href="#">copay</a> /hearing exam visit;<br><a href="#">deductible</a> does not apply | Not covered                                        | Limited to one adult eye exam every year.<br>Limited to one hearing exam every year.                                                                                                      |
|                                                                        | <a href="#">Preventive care/screening/immunization</a> | No charge for most services.<br>\$40 <a href="#">copay</a> /visit, <a href="#">deductible</a> does not apply or 40% <a href="#">coinsurance</a> for remaining services.                                                                                                          | Not covered                                        | You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for. |
| If you have a test                                                     | <a href="#">Diagnostic test</a> (x-ray, blood work)    | 40% <a href="#">coinsurance</a>                                                                                                                                                                                                                                                  | Not covered                                        | Includes other tests such as EKG, allergy testing and sleep study. <a href="#">Preauthorization</a> may be required. Failure to get <a href="#">preauthorization</a> results in denial.   |
|                                                                        | Imaging (CT/PET scans, MRIs)                           | 40% <a href="#">coinsurance</a>                                                                                                                                                                                                                                                  | Not covered                                        | <a href="#">Preauthorization</a> may be required. Failure to get <a href="#">preauthorization</a> results in denial.                                                                      |

| Common Medical Event                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Services You May Need                            | What You Will Pay                                                                                                                                                     |                                                                                            | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                  | Network Provider<br>(You will pay the least)                                                                                                                          | Out-of-Network Provider<br>(You will pay the most)                                         |                                                                                                                                                                                                                                       |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <a href="https://www.modahealth.com/texas/-/media/Texas/Downloads/Share/Documents/ModaHealth-Texas-Individual-Plans-Formulary.pdf">prescription drug coverage</a> is available at <a href="https://www.modahealth.com/texas/-/media/Texas/Downloads/Share/Documents/ModaHealth-Texas-Individual-Plans-Formulary.pdf">https://www.modahealth.com/texas/-/media/Texas/Downloads/Share/Documents/ModaHealth-Texas-Individual-Plans-Formulary.pdf</a> | Value drug tier                                  | \$2 <a href="#">copay</a> /retail prescription, \$6 <a href="#">copay</a> /90-day retail and mail order prescription; <a href="#">deductible</a> does not apply       | \$2 <a href="#">copay</a> /retail prescription, <a href="#">deductible</a> does not apply  | Covers up to a 30-day supply (retail pharmacy) and 90-day supply (mail order and participating retail pharmacies). One <a href="#">copay</a> for each 30-day supply. Mail order at a Moda Health designated mail order pharmacy only. |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Generic drugs (Select tier)                      | \$20 <a href="#">copay</a> /retail prescription, \$60 <a href="#">copay</a> /90-day retail and mail order prescription; <a href="#">deductible</a> does not apply     | \$20 <a href="#">copay</a> /retail prescription, <a href="#">deductible</a> does not apply |                                                                                                                                                                                                                                       |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Preferred brand drug tier                        | 40% <a href="#">coinsurance</a> , <a href="#">deductible</a> does not apply                                                                                           | 40% <a href="#">coinsurance</a> , <a href="#">deductible</a> does not apply                | Covers up to a 30-day supply for most specialty. Moda Health designated pharmacy only.<br><br><a href="#">Cost sharing</a> for anticancer medication is 40% <a href="#">coinsurance</a> .                                             |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Non-preferred brand drug tier                    | 50% <a href="#">coinsurance</a>                                                                                                                                       | 50% <a href="#">coinsurance</a>                                                            |                                                                                                                                                                                                                                       |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | <a href="#">Specialty drug</a> tier              | 40% <a href="#">coinsurance</a> for preferred, <a href="#">deductible</a> does not apply; 50% <a href="#">coinsurance</a> for non-preferred                           | Not covered                                                                                | Maximum <a href="#">cost sharing</a> for insulin per 30-day prescription fill is \$25.<br><br><a href="#">Preauthorization</a> may be required.                                                                                       |
| <b>If you have outpatient surgery</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Facility fee (e.g., ambulatory surgery center)   | 40% <a href="#">coinsurance</a>                                                                                                                                       | Not covered                                                                                | <a href="#">Preauthorization</a> may be required. Failure to get <a href="#">preauthorization</a> results in denial.                                                                                                                  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Physician/surgeon fees                           | 40% <a href="#">coinsurance</a>                                                                                                                                       | Not covered                                                                                |                                                                                                                                                                                                                                       |
| <b>If you need immediate medical attention</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | <a href="#">Emergency room care</a>              | 50% <a href="#">coinsurance</a>                                                                                                                                       | 50% <a href="#">coinsurance</a> in-network <a href="#">deductible</a> applies              | None                                                                                                                                                                                                                                  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | <a href="#">Emergency medical transportation</a> | 40% <a href="#">coinsurance</a>                                                                                                                                       | 40% <a href="#">coinsurance</a> in-network <a href="#">deductible</a> applies              | None                                                                                                                                                                                                                                  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | <a href="#">Urgent care</a>                      | \$70 <a href="#">copay</a> /office visit, \$30 <a href="#">copay</a> /virtual care visit, No charge/CirrusMD virtual visit; <a href="#">deductible</a> does not apply | Not covered                                                                                | None                                                                                                                                                                                                                                  |

| Common Medical Event                                                      | Services You May Need                     | What You Will Pay                                                                                                                                                                                                                    |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                   |
|---------------------------------------------------------------------------|-------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                           |                                           | Network Provider<br>(You will pay the least)                                                                                                                                                                                         | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                          |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)        | 40% <a href="#">coinsurance</a>                                                                                                                                                                                                      | Not covered                                        | <a href="#">Preauthorization</a> may be required. Failure to get <a href="#">preauthorization</a> results in denial.                                                                                                                                                                                                     |
|                                                                           | Physician/surgeon fees                    | 40% <a href="#">coinsurance</a>                                                                                                                                                                                                      | Not covered                                        |                                                                                                                                                                                                                                                                                                                          |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                       | \$40 <a href="#">copay</a> /office visit, \$30 <a href="#">copay</a> /virtual care visit, No charge/CirrusMD virtual visit; <a href="#">deductible</a> does not apply. 40% <a href="#">coinsurance</a> for other outpatient services | Not covered                                        | <a href="#">Preauthorization</a> may be required. Failure to get <a href="#">preauthorization</a> results in denial.                                                                                                                                                                                                     |
|                                                                           | Inpatient services                        | 40% <a href="#">coinsurance</a>                                                                                                                                                                                                      | Not covered                                        | <a href="#">Preauthorization</a> may be required. Failure to get <a href="#">preauthorization</a> results in denial.                                                                                                                                                                                                     |
| If you are pregnant                                                       | Office visits                             | 40% <a href="#">coinsurance</a>                                                                                                                                                                                                      | Not covered                                        | <a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of services, a <a href="#">copay</a> , <a href="#">coinsurance</a> or <a href="#">deductible</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). |
|                                                                           | Childbirth/delivery professional services | 40% <a href="#">coinsurance</a>                                                                                                                                                                                                      | Not covered                                        |                                                                                                                                                                                                                                                                                                                          |
|                                                                           | Childbirth/delivery facility services     | 40% <a href="#">coinsurance</a>                                                                                                                                                                                                      | Not covered                                        |                                                                                                                                                                                                                                                                                                                          |
| If you need help recovering or have other special health needs            | <a href="#">Home health care</a>          | 40% <a href="#">coinsurance</a>                                                                                                                                                                                                      | Not covered                                        | Calendar year maximum of 60 visits                                                                                                                                                                                                                                                                                       |
|                                                                           | <a href="#">Rehabilitation services</a>   | \$70 <a href="#">copay</a> /outpatient visit, <a href="#">deductible</a> does not apply. 40% <a href="#">coinsurance</a> for inpatient                                                                                               | Not covered                                        | Calendar year maximum of 35 outpatient sessions . Limits apply separately to rehabilitation and habilitation. Spinal manipulation included in outpatient <a href="#">rehabilitation services</a> . <a href="#">Preauthorization</a> may be required. Failure to get <a href="#">preauthorization</a> results in denial.  |
|                                                                           | <a href="#">Habilitation services</a>     | \$70 <a href="#">copay</a> /outpatient visit, <a href="#">deductible</a> does not apply. 40% <a href="#">coinsurance</a> for inpatient                                                                                               | Not covered                                        |                                                                                                                                                                                                                                                                                                                          |

| Common Medical Event                                           | Services You May Need                     | What You Will Pay                            |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                  |
|----------------------------------------------------------------|-------------------------------------------|----------------------------------------------|----------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                |                                           | Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                         |
| If you need help recovering or have other special health needs | <a href="#">Skilled nursing care</a>      | 40% <a href="#">coinsurance</a>              | Not covered                                        | Calendar year maximum of 25 days                                                                                                                                                                                                        |
|                                                                | <a href="#">Durable medical equipment</a> | 40% <a href="#">coinsurance</a>              | Not covered                                        | Includes supplies and prosthetics. Frequency limits apply to some <a href="#">durable medical equipment</a> (DME). <a href="#">Preauthorization</a> may be required. Failure to get <a href="#">preauthorization</a> results in denial. |
|                                                                | <a href="#">Hospice services</a>          | 40% <a href="#">coinsurance</a>              | Not covered                                        | <a href="#">Preauthorization</a> may be required. Failure to get <a href="#">preauthorization</a> 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 <a href="#">screening</a> for children age 3-5 at no <a href="#">cost sharing</a> .                                           |
|                                                                | 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 substances
- 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](http://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 <a href="#">plan's</a> overall <a href="#">deductible</a> | \$7,000 |
| ■ <a href="#">Specialist copayment</a>                          | \$70    |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 40%     |
| ■ Other <a href="#">coinsurance</a>                             | 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*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,700</b> |
|---------------------------|-----------------|

In this example, Peg would pay:

| <i>Cost Sharing</i>         |         |
|-----------------------------|---------|
| <a href="#">Deductibles</a> | \$7,000 |
| <a href="#">Copayments</a>  | \$0     |
| <a href="#">Coinsurance</a> | \$1,000 |

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

|                                   |                |
|-----------------------------------|----------------|
| <b>The total Peg would pay is</b> | <b>\$8,050</b> |
|-----------------------------------|----------------|

### Managing Joe's Type 2 Diabetes

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

|                                                                 |         |
|-----------------------------------------------------------------|---------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$7,000 |
| ■ <a href="#">Specialist copayment</a>                          | \$70    |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 40%     |
| ■ Other <a href="#">coinsurance</a>                             | 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$5,600</b> |
|---------------------------|----------------|

In this example, Joe would pay:

| <i>Cost Sharing</i>         |         |
|-----------------------------|---------|
| <a href="#">Deductibles</a> | \$400   |
| <a href="#">Copayments</a>  | \$400   |
| <a href="#">Coinsurance</a> | \$1,700 |

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

|                                   |                |
|-----------------------------------|----------------|
| <b>The total Joe would pay is</b> | <b>\$2,520</b> |
|-----------------------------------|----------------|

### Mia's Simple Fracture

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

|                                                                 |         |
|-----------------------------------------------------------------|---------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$7,000 |
| ■ <a href="#">Specialist copayment</a>                          | \$70    |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 40%     |
| ■ Other <a href="#">coinsurance</a>                             | 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,800</b> |
|---------------------------|----------------|

In this example, Mia would pay:

| <i>Cost Sharing</i>         |         |
|-----------------------------|---------|
| <a href="#">Deductibles</a> | \$2,300 |
| <a href="#">Copayments</a>  | \$300   |
| <a href="#">Coinsurance</a> | \$0     |

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

|                                   |                |
|-----------------------------------|----------------|
| <b>The total Mia would pay is</b> | <b>\$2,600</b> |
|-----------------------------------|----------------|

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

# Nondiscrimination notice

**We follow federal civil rights laws. We do not discriminate based on race, religion, color, national origin, age, disability, gender identity, sex or sexual orientation.**

We provide free services to people with disabilities so that they can communicate with us. These include sign language interpreters and other forms of communication.

If your first language is not English, we will give you free interpretation services and/or materials in other languages.

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**If you need any of the above, call:**

888-217-2363 (TDD/TTY 711)

**If you think we did not offer these services or discriminated, you can file a written complaint.**

**Please mail or fax it to:**

Moda Partners, Inc.  
Attention: Appeal Unit  
601 SW Second Ave.  
Portland, OR 97204  
Fax: 503-412-4003

**If you need help filing a complaint, please call Customer Service.**

You can also file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights at [ocrportal.hhs.gov/ocr/portal/lobby.jsf](http://ocrportal.hhs.gov/ocr/portal/lobby.jsf), or by mail or phone:

U.S. Department of Health  
and Human Services  
200 Independence Ave. SW, Room 509F  
HHH Building, Washington, DC 20201  
800-368-1019, 800-537-7697 (TDD)

You can get Office for Civil Rights complaint forms at [hhs.gov/ocr/office/file/index.html](http://hhs.gov/ocr/office/file/index.html).

**Scott White coordinates our nondiscrimination work:**

Scott White,  
Compliance Officer  
601 SW Second Ave.  
Portland, OR 97204  
855-232-9111  
[compliance@modahealth.com](mailto:compliance@modahealth.com)

[modahealth.com/texas](http://modahealth.com/texas)

ATENCIÓN: Si habla español, hay disponibles servicios de ayuda con el idioma sin costo alguno para usted. Llame al 1-877-605-3229 (TTY: 711).

CHÚ Ý: Nếu bạn nói tiếng Việt, có dịch vụ hỗ trợ ngôn ngữ miễn phí cho bạn. Gọi 1-877-605-3229 (TTY: 711)

注意：如果您說中文，可得到免費語言幫助服務。請致電1-877-605-3229（聾啞人專用：711）

주의: 한국어로 무료 언어 지원 서비스를 이용하시려면 다음 연락처로 연락해주시기 바랍니다. 전화 1-877-605-3229 (TTY: 711)

PAUNAWA: Kung nagsasalita ka ng Tagalog, ang mga serbisyong tulong sa wika, ay walang bayad, at magagamit mo. Tumawag sa numerong 1-877-605-3229 (TTY: 711)

تنبيه: إذا كنت تتحدث العربية، فهناك خدمات مساعدة لغوية متاحة لك مجانًا. اتصل برقم (الهاتف النصي: 711) 1-877-605-3229

ہولتے ہیں تو لسانی (URDU) توجہ دیں: اگر آپ اردو اعانت آپ کے لیے بلا معاوضہ دستیاب ہے۔ 1-877-605-3229 (TTY: 711) پر کال کریں

ВНИМАНИЕ! Если Вы говорите по-русски, воспользуйтесь бесплатной языковой поддержкой. Позвоните по тел. 1-877-605-3229 (текстовый телефон: 711).

ATTENTION : si vous êtes locuteurs francophones, le service d'assistance linguistique gratuit est disponible. Appelez au 1-877-605-3229 (TTY: 711)

توجہ: در صورتی کہ بہ فارسی صحبت می کنید، خدمات ترجمہ بہ صورت رایگان برای شما موجود است. با (TTY: 711) 1-877-605-3229 تماس بگیرید.

ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपको भाषाई सहायता बिना कोई पैसा दिए उपलब्ध है। 1-877-605-3229 पर कॉल करें (TTY: 711)

Achtung: Falls Sie Deutsch sprechen, stehen Ihnen kostenlos Sprachassistentendienste zur Verfügung. Rufen sie 1-877-605-3229 (TTY: 711)

注意：日本語をご希望の方には、日本語サービスを無料で提供しております。1-877-605-3229（TTY、テレタイプライターをご利用の方は711）までお電話ください。

အသံကုန်: နဂါး တမံ (မူလက နဂါး အသံကုန်) အသံကုန် ဖြစ်သော အသံကုန် တမံကုန် မှာ အသံကုန် မူလကုန် အသံကုန် ဖြစ်သည်။ 1-877-605-3229 (TTY: 711) နှင့် နဂါး နဂါး

ໂປດຊາບ: ຖ້າທ່ານເວົ້າພາສາລາວ, ການຊ່ວຍເຫຼືອດ້ານພາສາແມ່ນມີໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ. ໂທ 1-877-605-3229 (TTY: 711)

УВАГА! Якщо ви говорите українською, для вас доступні безкоштовні консультації рідною мовою. Зателефонуйте 1-877-605-3229 (TTY: 711)

ATENȚIE: Dacă vorbiți limba română, vă punem la dispoziție serviciul de asistență lingvistică în mod gratuit. Sunați la 1-877-605-3229 (TTY 711)

THOV CEEB TOOM: Yog hais tias koj hais lus Hmoob, muaj cov kev pab cuam txhais lus, pub dawb rau koj. Hu rau 1-877-605-3229 (TTY: 711)

ត្រូវចងចាំ: បើអ្នកនិយាយភាសាខ្មែរ ហើយ ត្រូវការសេវាកម្មជំនួយផ្នែកភាសាដោយ ឥតគិតថ្លៃ គឺមានផ្តល់ជូនលោកអ្នក។ សូមទូរស័ព្ទ ទៅកាន់លេខ 1-877-605-3229 (TTY: 711)

HUBACHIIISA: Yoo afaan Kshtik kan dubbattan ta'e tajaqjiloonni gargaarsaa isiniif jira 1-877-605-3229 (TTY: 711) tiin bilbilaa.

โปรดทราบ: หากคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือด้านภาษาได้ฟรี โทร 1-877-605-3229 (TTY: 711)

FA'AUTAGIA: Afai e te tautala i le gagana Samoa, o loo avanoa fesoasoani tau gagana mo oe e le totogia. Vala'au i le 1-877-605-3229 (TTY: 711)

IPANGAG: Nu agsasaoka iti Ilocano, sidadaan ti tulong iti lengguahe para kenka nga awan bayadna. Umawag iti 1-877-605-3229 (TTY: 711)

UWAGA: Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń: 1-877-605-3229 (obsługa TTY: 711)