Coverage Period: 01/01/2022-12/31/2022 Coverage for: Family | Plan Type: PPO

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 in-network benefits, \$5,000 individual/ \$10,000 family; for out-of-network benefits, \$10,000 individual / \$20,000 family. In-network benefit level (including cost sharing and out-of-pocket limit) for out-of-network providers in Alaska other than hospitals within 50 miles of Alaska Regional Hospital.	Generally, you must pay all of the costs from providers up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. Examples of some services: In-network office visits for primary care, specialist and urgent care, virtual care visits, most preventive care, office visits for outpatient mental health and chemical dependency services, outpatient rehabilitation, as well as most in and out-of-network prescription medications are covered before you meet your deductible.	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> 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 <u>out-of-</u> <u>pocket limit</u> for this <u>plan</u> ?	For in-network benefits \$8,550 individual / \$17,100 family; for out-of-network benefits \$45,000 individual / \$90,000 family.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limits</u> has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, penalties for failure to obtain prior authorization for services, expenses incurred due to brand substitution, out-of-network benefit expenses, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket</u> <u>limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See www.modahealth.com or call 1-888-873-1395 for a list of	

Important Questions	Answers	Why This Matters:
		<u>provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical	Samilaga Vay May	What You Wil	II Pay	Limitations Eventions 9 Other Important
Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Primary care visit to treat an injury or illness	\$40 copay/office visit, \$30 copay/virtual care visit, No charge/CirrusMD virtual visit; deductible does not apply	50% coinsurance	None
office or clinic	<u>Specialist</u> visit	\$40 copay/visit for spinal manipulation, acupuncture and massage therapy, \$30 copay/virtual care visit; No charge/CirrusMD virtual visit, \$80 copay/visit for other visits; deductible does not apply	50% coinsurance	Office visits by naturopaths, acupuncturists and chiropractors are considered specialist visits unless they are listed as PCPs in the network. Spinal manipulation, massage therapy and acupuncture are each limited to 24 visits per year. Prior authorization may be required for some spinal manipulation, massage therapy and acupuncture services. Failure to obtain prior authorization may result in denial or a penalty of 50% up to a maximum deduction of \$2,500.
	Preventive care / screening / immunization	No charge for most services. 30% coinsurance for remaining services, deductible does not apply	50% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
	Diagnostic test (x- ray, blood work)	30% coinsurance	50% coinsurance	Includes other tests such as EKG, allergy testing and sleep study.
If you have a test	Imaging (CT/PET scans, MRIs)	30% coinsurance	50% coinsurance	Prior authorization may be required for many services. Failure to obtain prior authorization may result in denial or a penalty of 50% up to a maximum deduction of \$2,500.

^{*} For more information about limitations and exceptions, see the <u>plan</u> or policy document at <u>www.modahealth.com</u>.

Common Medical		What You Will Pay		Limitations, Exceptions, & Other	
Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Important Information	
	Value tier	No charge	No charge		
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.modahealth.com/pdl	Select tier	\$10 copay/retail prescription, \$30 copay/90-day retail and mail- order prescription; deductible does not apply	\$10 <u>copay</u> /retail prescription, <u>deductible</u> does not apply	Prior authorization may be required. Covers up to a 90-day supply for retail and	
	Preferred tier	\$30 copay/retail prescription, \$90 copay/90-day retail and mail- order prescription deductible does not apply	\$30 copay/retail prescription, deductible does not apply	mail order prescriptions. One copay for each 30-day retail supply. Mail order at a Moda Health designated mail order pharmacy only.	
	Non-preferred tier	\$50 copay/retail prescription, \$150 copay/90-day retail and mail-order prescription; deductible does not apply	\$50 copay/retail prescription, deductible does not apply	Covers up to a 30-day supply for most specialty. Moda Health designated pharmacy only.	
	Specialty tier	\$150 copay/specialty preferred prescription, 30% coinsurance/specialty non-preferred prescription; deductible does not apply	Not covered	Cost sharing for anticancer medication is 20% coinsurance.	
If you have outpatient	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	50% coinsurance	Prior authorization may be required. Failure to obtain prior authorization may result in	
surgery	Physician/surgeon fees	30% coinsurance	50% coinsurance	denial or a penalty of 50% up to a maximum deduction of \$2,500.	
If you need immediate medical attention	Emergency room care	\$40 <u>copay</u> /visit, <u>deductible</u> does not apply	\$40 <u>copay</u> /visit, <u>deductible</u> does not apply	Copay waived if hospital admission immediately follows. Plan deductible and coinsurance may apply to some services. In-network out-of-pocket limit applies.	
	Emergency medical transportation	30% coinsurance	30% coinsurance	Ambulance transportation is limited to a maximum of 6 trips per calendar year. Commercial transportation is limited to one-way for a sudden, life-endangering medical condition. In-network deductible and out-of-pocket limit apply.	

 $^{^{\}star}$ For more information about limitations and exceptions, see the <u>plan</u> or policy document at <u>www.modahealth.com</u>.

	Comisso Vou May	What You Will Pay		Limitations Expansions & Other Important	
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information	
If you need immediate medical attention	Urgent care	\$80 copay/office visit, \$30 copay/virtual care visit, No charge/CirrusMD virtual visit; deductible does not apply	50% coinsurance	None	
If you have a hospital	Facility fee (e.g., hospital room)	30% coinsurance	50% coinsurance	Prior authorization may be required. Failure to obtain prior authorization may result in denial or a	
stay	Physician/surgeon fees	30% coinsurance	50% coinsurance	penalty of 50% up to a maximum deduction of \$2,500.	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$40 copay/office visit, \$30 copay/virtual care visit No charge/CirrusMD virtual visit deductible does not apply. 30% coinsurance for other outpatient services.	50% coinsurance	Prior authorization may be required for some outpatient behavioral health services. Failure to obtain prior authorization may result in denial or a penalty of 50% up to a maximum deduction of \$2,500.	
	Inpatient services	30% coinsurance	50% coinsurance	Prior authorization may be required for inpatient and residential services. Failure to obtain prior authorization may result in denial or a penalty of 50% up to a maximum deduction of \$2,500.	
	Office visits	30% coinsurance	50% coinsurance	Cost sharing does not apply to certain preventive	
If you are pregnant	Childbirth/delivery professional services	30% coinsurance	50% coinsurance	services. Depending on the type of services, a copay, coinsurance, or deductible may apply.	
	Childbirth/delivery facility services	30% coinsurance	50% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).	
	Home health care	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Calendar year maximum of 140 visits	
If you need help recovering or have other special health needs	Rehabilitation services	\$80 <u>copay</u> /outpatient visit, <u>deductible</u> does not apply. 30% <u>coinsurance</u> for inpatient	50% coinsurance	Calendar year maximum of 30 days for inpatient rehabilitation and 30 sessions for outpatient rehabilitation. May be eligible for up to 60 days inpatient or up to 60 sessions for outpatient rehabilitation for head or spinal cord injury. Prior authorization may be required. Failure to obtain prior authorization may result in denial or a penalty of 50% up to a maximum deduction of \$2,500.	

 $^{^{\}star}$ For more information about limitations and exceptions, see the <u>plan</u> or policy document at <u>www.modahealth.com</u>.

Common Madical	Services You May Need	What You Will Pay		Limitations Everytions 9 Other languages
Common Medical Event		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Habilitation services	Not covered	Not covered	None
	Skilled nursing care	30% coinsurance	50% coinsurance	Calendar year maximum of 30 days
If you need help recovering or have other special health needs	Durable medical equipment	30% coinsurance	50% coinsurance	Includes items such as supplies and prosthetics. Frequency limits apply to some DME. Prior authorization may be required. Failure to obtain prior authorization may result in denial or a penalty of 50% up to a maximum deduction of \$2,500.
	Hospice services	30% coinsurance	50% coinsurance	Calendar year maximum of 12 days for inpatient and 170 hours for respite care.
If you washild was do	Children's eye exam	No charge	50% coinsurance	Limited to preventive eye screening for children age 3-5. Eye exams are not covered for other ages.
If your child needs dental or eye care	Children's glasses	Not covered	Not covered	None
	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.)

- Bariatric surgery
- Cosmetic surgery, except as required for certain situations
- Dental care (Adult) except for accident related injuries
- Habilitation services
- Hearing Aids
- Infertility treatment
- Long term care
- Naturopathic supplies

- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Routine eye care (Adult)
- Routine foot care, except for diabetes
- Weight loss programs

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

Abortion
 Acupuncture
 Chiropractic care

^{*} For more information about limitations and exceptions, see the <u>plan</u> or policy document at <u>www.modahealth.com</u>.

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, and 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.tealth.lnsurance 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. 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. Additionally, a consumer assistance program can help you file your appeal. Contact the Alaska Division of Insurance at 1-800-467-8725 or http://www.commerce.state.ak.us/ins/Insurance/consumer.html.

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 888-500-0343.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 888-500-0343.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 888-500-0343.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

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

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost-sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. 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 <u>plan's</u> overall <u>deductible</u>	\$5,000
■ Specialist copayment	\$80
■ Hospital (facility) coinsurance	30%
■ Other coinsurance	30%

This EXAMPLE event includes services like:

Specialist office visits (prenatal care)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (ultrasounds and blood work)
Specialist visit (anesthesia)

Total Example Cost	\$12,700		
In this example, Peg would pay:			
Cost Sharing			
<u>Deductibles</u>	\$5,000		
<u>Copayments</u>	\$10		
Coinsurance	\$2,300		
What isn't covered			
Limits or exclusions	\$50		
The total Peg would pay is	\$7,360		

Managing Joe's Type 2 Diabetes

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

■ The <u>plan's</u> overall <u>deductible</u>	\$5,000
■ Specialist copayment	\$80
■ Hospital (facility) coinsurance	30%
■ Other <u>coinsurance</u>	30%

This EXAMPLE event includes services like:

<u>Primary care physician</u> office visits (including disease education)

Diagnostic tests (blood work)

Prescription drugs

Durable medical equipment (glucose meter)

Total Example Cost	\$5,600	
In this example, Joe would pay:		
Cost Sharing		
<u>Deductibles</u>	\$400	
Copayments	\$1,200	
Coinsurance	\$0	
What isn't covered		
Limits or exclusions	\$20	
The total Joe would pay is	\$1,620	

Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$5,000
■ Specialist copayment	\$80
■ Hospital (facility) coinsurance	30%
■ Other <u>coinsurance</u>	30%

This EXAMPLE event includes services like:

Emergency room care (including medical supplies)

Diagnostic test (x-ray)

Durable medical equipment (crutches)

Rehabilitation services (physical therapy)

Total Example Cost	\$2,800
In this example, Mia would pay:	
Cost Sharing	
<u>Deductibles</u>	\$1,700
Copayments	\$300
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$2,000

The <u>plan</u> 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, 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.

If you need any of the above, call Customer Service at:

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

Dave Nesseler-Cass coordinates our nondiscrimination work:

Dave Nesseler-Cass, Chief Compliance Officer 601 SW Second Ave. Portland, OR 97204 855-232-9111 compliance@modahealth.com

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, 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.





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 hổ 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 222-605-711 (الهاتف النصى: 711)

بولتے ہیں تو ل انی (URDU) توجب دیں: اگر آپ اردو اعانت آپ کے لیے بلا معاوض دستیاب ہے۔ پر کال کریں (TTY: 711) 2226-605-1-877

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)

توجه: در صورتی که به فارسی صحبت می کنید، خدمات ترجمه به صورت رایگان برای شما موجود است. با 222-605-701) 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 Sprachassistenzdienste 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 (TYY、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。 અગત્યનું: જો તમે (ભાષાંતર કરેલ ભાષા અહીં દશારવો) બોલો છો તો તે ભાષામાં તમારે માટે વિના મૂલ્યે સહાય ઉપલબ્ધ છે.1-877-605-3229 (TTY: 711) પર કૉલ કરો

ໂປດຊາບ: ຖ້າທ່ານເວົ້າພາສາລາວ, ການຊ່ວ ຍເຫຼືອດ້ານພາສາແມ່ນມີໃຫ້ທ່ານໂດຍບໍ່ເສັຍ ຄ່າ. ໂທ 1-877-605-3229 (TTY: 711)

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

ត្រវចងចាំ៖ បើអ្នកនិយាយភាសាខ្មែរ ហើយត្រវ ការសេវាកម្មជំនូយផ្នែកភាសាដោយឥតគិតថ្លៃ៍ គឺមានផ្ដល់ជូនលោកអ្នក។ សូមទូរស័ព្ទទៅកាន់លេខ 1-877-605-3229 (TTY: 711)

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

โปรดหราบ: หากคุณพูดภาษาไหย คุณ สามารถใช้บริการช่วยเหลือด้านภาษา ได้ฟรี โหร 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)



