



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, \$500 individual/ \$1,000 family; for out-of-network benefits, \$1,000 individual / \$2,000 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 deductible amount before this plan begins to pay. If you have other family members on the plan , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible . |
| Are there services covered before you meet your deductible? | Yes. 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 diagnostic tests , outpatient rehabilitation, as well as most in and out-of-network prescription medications are covered before you meet your deductible . | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ . |
| Are there other deductibles for specific services? | No. | You don't have to meet deductibles for specific services. |
| What is the out-of-pocket limit for this plan? | For in-network benefits \$6,500 individual / \$13,000 family; for out-of-network benefits \$45,000 individual / \$90,000 family. | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| What is not included in the out-of-pocket limit? | Premiums , balance-billing charges, 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 out-of-pocket limit . |
| Will you pay less if you use a network provider? | Yes. See www.modahealth.com or call 1-888-873-1395 for a list of network providers . | This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab |

| Important Questions | Answers | Why This Matters: |
|--|---------|--|
| | | work). Check with your provider before you get services. |
| Do you need a referral to see a specialist ? | No. | You can see the specialist you choose without a referral . |



All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|--|---|--|--|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness | \$20 copay /office visit, \$10 copay /virtual care visit, No charge/CirrusMD virtual visit; deductible does not apply | 50% coinsurance | None |
| | Specialist visit | \$20 copay /visit for spinal manipulation, acupuncture and massage therapy, \$10 copay /virtual care visit; No charge/CirrusMD virtual visit, \$50 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. 20% 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. |
| If you have a test | Diagnostic test (x-ray, blood work) | 20% coinsurance ; deductible does not apply to outpatient services / office setting. | 50% coinsurance | Includes other tests such as EKG, allergy testing and sleep study. |
| | Imaging (CT/PET scans, MRIs) | 20% 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. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|--|--|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.modahealth.com/pdl | Value tier | No charge | No charge | Prior authorization may be required. |
| | Select, Preferred, and Non-preferred tiers | \$15 copay or 50% coinsurance , whichever is greater, retail prescription \$45 copay or 50% coinsurance , whichever is greater, 90-day retail and mail order prescription; deductible does not apply | \$15 copay or 50% coinsurance , whichever is greater, retail prescription; deductible does not apply | Covers up to a 90-day supply for retail and mail order prescriptions. One copay for each 30-day retail supply. Mail order at a Moda Health designated mail order pharmacy only. |
| | Specialty tier | \$15 copay or 50% coinsurance , whichever is greater; deductible does not apply | Not covered | Covers up to a 30-day supply for most specialty. Moda Health designated pharmacy only. Cost sharing for anticancer medication is 20% coinsurance . |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | 50% coinsurance | 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. |
| | Physician/surgeon fees | 20% coinsurance | 50% coinsurance | |
| If you need immediate medical attention | Emergency room care | \$20 copay /visit, deductible does not apply | \$20 copay /visit, deductible 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 | 20% coinsurance | 20% 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. |
| | Urgent care | \$50 copay /office visit, \$10 copay /virtual care visit, No charge/CirrusMD virtual visit; deductible does not apply | 50% coinsurance | None |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|--|--|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 20% coinsurance | 50% coinsurance | 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. |
| | Physician/surgeon fees | 20% coinsurance | 50% coinsurance | |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | \$20 copay /office visit, \$10 copay /virtual care visit No charge/CirrusMD virtual visit deductible does not apply. 20% 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 | 20% 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. |
| If you are pregnant | Office visits | 20% coinsurance | 50% coinsurance | Cost sharing does not apply to certain preventive services . Depending on the type of services, a copay , coinsurance , or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
| | Childbirth/delivery professional services | 20% coinsurance | 50% coinsurance | |
| | Childbirth/delivery facility services | 20% coinsurance | 50% coinsurance | |
| If you need help recovering or have other special health needs | Home health care | 20% coinsurance | 50% coinsurance | Calendar year maximum of 140 visits |
| | Rehabilitation services | \$50 copay /outpatient visit, deductible does not apply. 20% coinsurance 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. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|--|--|--|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you need help recovering or have other special health needs | Habilitation services | Not covered | Not covered | None |
| | Skilled nursing care | 20% coinsurance | 50% coinsurance | Calendar year maximum of 30 days |
| | Durable medical equipment | 20% 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 | 20% coinsurance | 50% coinsurance | Calendar year maximum of 12 days for inpatient and 170 hours for respite care. |
| If your child needs dental or eye care | 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. |
| | 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 | • Habilitation services | • Non-emergency care when traveling outside the U.S. |
| • Cosmetic surgery, except as required for certain situations | • Hearing Aids | • Private duty nursing |
| • Dental care (Adult) except for accident related injuries | • Infertility treatment | • Routine eye care (Adult) |
| | • Long term care | • Routine foot care, except for diabetes |
| | • Naturopathic supplies | • 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 |
|------------|---------------|---------------------|

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.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information on how to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: Moda Health at 1-888-873-1395. 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): Dine'ehgo shika at'ohwol ninisingo, kwijigo holne' 888-500-0343.

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

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost-sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

| | |
|---|-------|
| ■ The plan's overall deductible | \$500 |
| ■ Specialist copayment | \$50 |
| ■ Hospital (facility) coinsurance | 20% |
| ■ Other coinsurance | 20% |

This EXAMPLE event includes services like:

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

| | |
|---------------------------|-----------------|
| Total Example Cost | \$12,700 |
|---------------------------|-----------------|

In this example, Peg would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| Deductibles | \$500 |
| Copayments | \$10 |
| Coinsurance | \$2,400 |
| What isn't covered | |
| Limits or exclusions | \$50 |
| The total Peg would pay is | \$2,960 |

Managing Joe's Type 2 Diabetes

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

| | |
|---|-------|
| ■ The plan's overall deductible | \$500 |
| ■ Specialist copayment | \$50 |
| ■ Hospital (facility) coinsurance | 20% |
| ■ Other coinsurance | 20% |

This EXAMPLE event includes services like:

[Primary care physician](#) office visits (*including disease education*)
[Diagnostic tests](#) (*blood work*)
[Prescription drugs](#)
[Durable medical equipment](#) (*glucose meter*)

| | |
|---------------------------|----------------|
| Total Example Cost | \$5,600 |
|---------------------------|----------------|

In this example, Joe would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| Deductibles | \$200 |
| Copayments | \$200 |
| Coinsurance | \$2,100 |
| What isn't covered | |
| Limits or exclusions | \$20 |
| The total Joe would pay is | \$2,520 |

Mia's Simple Fracture

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

| | |
|---|-------|
| ■ The plan's overall deductible | \$500 |
| ■ Specialist copayment | \$50 |
| ■ Hospital (facility) coinsurance | 20% |
| ■ Other coinsurance | 20% |

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)
[Diagnostic test](#) (*x-ray*)
[Durable medical equipment](#) (*crutches*)
[Rehabilitation services](#) (*physical therapy*)

| | |
|---------------------------|----------------|
| Total Example Cost | \$2,800 |
|---------------------------|----------------|

In this example, Mia would pay:

| Cost Sharing | |
|-----------------------------------|--------------|
| Deductibles | \$500 |
| Copayments | \$200 |
| Coinsurance | \$200 |
| What isn't covered | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$900 |

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, 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

**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.

**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

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

بولتے ہیں تو لانی (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。

အကူအညီ: နှစ် ဘာသာစုံ (မူလအား အင်္ဂလိပ် အစရှိသော) ဝေါဟာရ တို့ကို အသုံးပြုနိုင်ရန် အကူအညီ ပေးပါမည့် ဝန်ဆောင်မှုများ ပေးပါမည်။ 1-877-605-3229 (TTY: 711) နှင့် နှိုင်း နှိုင်း

ໂປດຊາວ: 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 ហើយត្រូវការសេវាកម្មជំនួយផ្នែកភាសាដោយឥតគិតថ្លៃ គឺមានផ្តល់ជូនលោកអ្នក។ សូមទូរស័ព្ទទៅកាន់លេខ 1-877-605-3229 (TTY: 711)

HUBACHIIISA: Yoo afaan Kshtik kan dubbattan ta'e tajaajiloonni 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)