



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, contact Moda Health at www.modahealth.com or by calling 1-888-873-1395. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 1-888-873-1395 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	For network providers \$8,550 individual / \$17,100 family; for out-of-network providers \$17,100 individual / \$34,200 family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible .
Are there services covered before you meet your deductible ?	Yes. In-network preventive care and medical travel support, as well as in and out-of-network value and select prescription medications, children's routine eye exams and glasses, and hearing aid services are covered before you meet your deductible .	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan ?	For network providers \$8,550 individual / \$17,100 family; for out-of-network providers \$45,000 individual / \$90,000 family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit ?	Premiums , balance-billing charges, penalties for failure to obtain pre-authorization and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
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 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	0% coinsurance 0% coinsurance for CirrusMD virtual visit	50% coinsurance	Includes office visits by naturopaths.
	Specialist visit	0% coinsurance 0% coinsurance for CirrusMD virtual visit	50% coinsurance	Hearing services covered at 20% coinsurance , deductible does not apply. Spinal manipulation, massage therapy and acupuncture are each limited to 24 visits per year. Prior authorization may be required to avoid a penalty of 50% up to a maximum deduction of \$2,500.
	Preventive care/screening/immunization	No charge for most services, 0% coinsurance for remaining services; deductible does not apply for most services.	50% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance	50% coinsurance	Includes other tests such as EKG, allergy testing and sleep study.
	Imaging (CT/PET scans, MRIs)	0% coinsurance	50% coinsurance	Prior authorization may be required to avoid a penalty of 50% up to a maximum deduction of \$2,500.
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	Covers up to a 90-day supply for retail and mail order prescriptions. One copay for each 30-day supply. Mail order at a Moda Health designated mail order pharmacy only. Prior authorization may be required.
	Select tier	\$20 copay /prescription, deductible does not apply.	\$20 copay /prescription, deductible does not apply.	
	Preferred tier	0% coinsurance	0% coinsurance	
	Non-preferred tier	0% coinsurance	0% coinsurance	Covers up to a 30-day supply for most specialty medications. Prior authorization may be required. Moda Health designated specialty pharmacy only.
	Specialty tier	0% coinsurance	Not covered	Anticancer medication is covered at 0% coinsurance for in-network and 50% coinsurance for out-of-network providers .

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance No charge at a medical travel support facility for select surgeries	50% coinsurance	Prior authorization may be required to avoid a penalty of 50% up to a maximum deduction of \$2,500.
	Physician/surgeon fees	0% coinsurance No charge at a medical travel support facility for select surgeries	50% coinsurance	
If you need immediate medical attention	Emergency room care	0% coinsurance	0% coinsurance	In-network deductible and out-of-pocket limit apply.
	Emergency medical transportation	0% coinsurance	0% coinsurance	Commercial transportation is limited to one-way for a sudden, life-endangering medical condition. In-network deductible and out-of-pocket limit apply.
	Urgent care	0% coinsurance ; 0% coinsurance for CirrusMD virtual visit	50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	50% coinsurance	Prior authorization is required to avoid a penalty of 50% up to a maximum deduction of \$2,500.
	Physician/surgeon fees	0% coinsurance	50% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% coinsurance ; 0% coinsurance for CirrusMD virtual visit	50% coinsurance	Psychological or neuropsychological testing limited to 12 hours per year. Prior authorization may be required for some services to avoid a penalty of 50% up to a maximum deduction of \$2,500.
	Inpatient services	0% coinsurance	50% coinsurance	Prior authorization is required for inpatient and residential services to avoid a penalty of 50% up to a maximum deduction of \$2,500.
If you are pregnant	Office visits	0% coinsurance	50% coinsurance	Cost sharing does not apply for preventive services . Depending on the type of services, a copay , coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	0% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	0% coinsurance	50% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	0% coinsurance	50% coinsurance	Calendar year maximum of 130 visits.
	Rehabilitation services	0% coinsurance	50% coinsurance	Calendar year maximum of 30 days for inpatient and 45 sessions for outpatient rehabilitation and habilitation. Limits apply separately to outpatient rehabilitative and habilitative services. Prior authorization may be required to avoid a penalty of 50% up to a maximum deduction of \$2,500.
	Habilitation services	0% coinsurance	50% coinsurance	
	Skilled nursing care	0% coinsurance	50% coinsurance	Calendar year maximum of 60 days
	Durable medical equipment	0% coinsurance 20% coinsurance for hearing aids, deductible does not apply.	50% coinsurance 20% coinsurance for hearing aids, deductible does not apply.	Includes supplies and prosthetics. Frequency limits apply to some DME. Hearing aids are subject to a \$3,000 limit per 3-year period. Prior authorization may be required to avoid a penalty of 50% up to a maximum deduction of \$2,500.
	Hospice services	0% coinsurance	50% coinsurance	Lifetime maximum of 10 inpatient days and 240 hours respite care.
If your child needs dental or eye care	Children's eye exam	No charge	No charge	Limited to one eye exam per calendar year. Additional in-network preventive eye screening for children age 3-5 at no cost sharing . In-network eye exams for age 19 and over covered at \$10 copay /visit, deductible does not apply.
	Children's glasses	No charge	No charge	Coverage limited to one pair of glasses per calendar year for children under age 19. For age 19 and over, see member handbook for vision limits.
	Children's dental check-up	0% coinsurance	50% coinsurance	For members under age 19. Frequency limits apply to some services.

Excluded Services & Other Covered Services:

Services Your [Plan](#) Generally Does NOT Cover (Check your policy or [plan](#) document for more information and a list of any other [excluded services](#).)

- | | | |
|-------------------------|--|------------------------|
| • Bariatric surgery | • Long-term care | • Private-duty nursing |
| • Cosmetic surgery | • Naturopathic substances | • Routine foot care |
| • Dental care (Adult) | • Non-emergency care when traveling outside the U.S. | • Weight loss programs |
| • Infertility treatment | | |

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

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|---------------|---------------------|----------------------------|
| • Abortion | • Chiropractic care | • Hearing aids |
| • Acupuncture | | • Routine eye care (Adult) |

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or <http://www.dol.gov/ebsa/healthreform> for group health coverage subject to ERISA, the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov for non-federal governmental group health plans, the Alaska Division of Insurance at 1-800-467-8725 or <http://www.commerce.state.ak.us/ins/Insurance/consumer.html> for Church plans. Other coverage options may be available to you too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318 2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information on how to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: Moda Health at 1-888-873-1395 or the Alaska Division of Insurance at <http://www.commerce.state.ak.us/ins/Insurance/consumer.html> or 1-800-467-8725. For group health coverage subject to ERISA, you may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes.

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

Does this plan meet the Minimum Value Standards? Yes.

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 888-786-7461.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 888-873-1395.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 888-873-1395.

Navajo (Dine): Dineek'ehgo shika at'ohwol ninisingo, kwijigo holne' 888-873-1395.

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

* 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 [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	\$8,550
■ Specialist coinsurance	0%
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	0%

This EXAMPLE event includes services like:

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

Total Example Cost	\$12,700
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$8,550
Copayments	\$0
Coinsurance	\$0

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

The total Peg would pay is	\$8,600
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Managing Joe's Type 2 Diabetes

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

■ The plan's overall deductible	\$8,550
■ Specialist coinsurance	0%
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	0%

This EXAMPLE event includes services like:

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

Total Example Cost	\$5,600
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$5,300
Copayments	\$0
Coinsurance	\$0

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

The total Joe would pay is	\$5,320
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Mia's Simple Fracture

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

■ The plan's overall deductible	\$8,550
■ Specialist coinsurance	0%
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	0%

This EXAMPLE event includes services like:

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

Total Example Cost	\$2,800
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$2,800
Copayments	\$0
Coinsurance	\$0

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

The total Mia would pay is	\$2,800
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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:**

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