




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 1-888-217-2363. 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 1-888-217-2363 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|--|--|
| <p>What is the overall deductible?</p> | <p>For network providers \$3,000 individual / \$6,000 family; for out-of-network providers \$9,000 individual / \$18,000 family.</p> | <p>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.</p> |
| <p>Are there services covered before you meet your deductible?</p> | <p>Yes. In-network primary care visits, office visits, urgent care visits, virtual care visits, outpatient rehabilitation, outpatient mental health and chemical dependency services, acupuncture, spinal manipulation, outpatient diagnostic x-rays and labs, biofeedback, tobacco cessation treatment, pediatric vision care, hearing exam, breastfeeding support, and most preventive care, as well as in and out of network most prescription medications, and breastfeeding supplies are covered before you meet your deductible.</p> | <p>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/.</p> |
| <p>Are there other deductibles for specific services?</p> | <p>No.</p> | <p>You don't have to meet deductibles for specific services.</p> |
| <p>What is the out-of-pocket limit for this plan?</p> | <p>For network providers \$8,150 individual / \$16,300 family; for out-of-network providers \$24,450 individual / \$48,900 family.</p> | <p>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.</p> |
| <p>What is not included in the out-of-pocket limit?</p> | <p>Premiums, balance-billing charges, and health care this plan doesn't cover.</p> | <p>Even though you pay these expenses, they don't count toward the out-of-pocket limit.</p> |

| Important Questions | Answers | Why This Matters: |
|--|--|---|
| Will you pay less if you use a network provider ? | Yes. See www.modahealth.com or call 1-888-217-2363 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 | \$40 copay /visit, no deductible \$30 copay /visit, no deductible for virtual care visits | 50% coinsurance | None. |
| | Specialist visit | \$40 copay /visit, no deductible for acupuncture and spinal manipulation. \$45 copay /visit, no deductible for hearing exam. \$30 copay /visit, no deductible for virtual care visits \$80 copay /visit, no deductible for other services | 50% coinsurance | Includes office visits by chiropractors, naturopathic physicians and acupuncturists. \$2,000 calendar year maximum for acupuncture care and spinal manipulation. Prior authorization is required for some spinal manipulation and acupuncture services. Failure to obtain prior authorization results in denial. |
| | Preventive care/screening /immunization | No charge for most services. \$40 copay /visit, no deductible or 40% coinsurance for remaining services. | Not covered for most services. 50% coinsurance for some services. | 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. A list of in-network preventive services not subject to cost sharing can be viewed at https://www.healthcare.gov/coverage/preventive-care-benefits/ . |
| If you have a test | Diagnostic test (x-ray, blood work) | 40% coinsurance , no deductible in outpatient/office setting | 50% coinsurance | Includes other tests such as EKG, allergy testing and sleep study. |
| | Imaging (CT/PET scans, MRIs) | 40% coinsurance | 50% coinsurance | Prior authorization is required for many services. Failure to obtain prior authorization results in denial. |

| 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 deductible . \$2 copay /retail prescription, \$6 copay /mail-order prescription | No deductible . \$2 copay /retail prescription | Covers up to a 30-day supply (standard retail pharmacy), 84 to 90-day supply (Choice 90 pharmacy), and 90-day supply (mail-order pharmacy). Prior authorization may be required. Mail order at Moda designated mail order pharmacy only. Covers up to a 30-day supply specialty. Prior authorization may be required. Moda designated pharmacy only. Anticancer medication is covered at the standard coinsurance rate for network providers and out-of-network providers . |
| | Select tier | No deductible . \$40 copay /retail prescription, \$120 copay /mail-order prescription | No deductible . \$40 copay /retail prescription | |
| | Preferred tier | No deductible . \$80 copay /retail prescription, \$240 copay /mail-order prescription | No deductible . \$80 copay /retail prescription | |
| | Non-Preferred tier | No deductible . 50% coinsurance | No deductible . 50% coinsurance . | |
| | Specialty tier | 40% coinsurance , no deductible for preferred. 50% coinsurance after deductible, for non-preferred | Not covered | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 40% coinsurance | 50% coinsurance | Prior authorization may be required. Failure to obtain prior authorization results in denial. |
| | Physician/surgeon fees | 40% coinsurance | 50% coinsurance | |
| If you need immediate medical attention | Emergency room care | \$250 copay /visit; then 40% coinsurance | \$250 copay /visit; then 40% coinsurance | Copay waived if hospital admission immediately follows. In-network deductible and out-of-pocket limits apply. |
| | Emergency medical transportation | 40% coinsurance | 40% coinsurance | Calendar year maximum of 6 trips. In-network deductible and out-of-pocket limits apply. |
| | Urgent care | \$40 copay /visit, no deductible \$30 copay /visit, no deductible for virtual care visits | 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) | 40% coinsurance | 50% coinsurance | Prior authorization is required. Failure to obtain prior authorization results in denial. |
| | Physician/surgeon fees | 40% coinsurance | 50% coinsurance | |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | \$40 copay /office visit, no deductible 40% coinsurance for other services \$30 copay /visit, no deductible for virtual care visits | 50% coinsurance | Prior authorization is required for some outpatient behavioral health services. Failure to obtain prior authorization results in denial.. |
| | Inpatient services | 40% coinsurance | 50% coinsurance | Prior authorization is required for all inpatient services. Failure to obtain prior authorization results in denial. |
| If you are pregnant | Office visits | 40% coinsurance | 50% coinsurance | In-network elective abortion is covered at no cost sharing. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Depending on the type of services, a copayment , coinsurance , or deductible may apply. Cost sharing does not apply to certain preventive services . |
| | Childbirth/delivery professional services | 40% coinsurance | 50% coinsurance | |
| | Childbirth/delivery facility services | 40% coinsurance | 50% coinsurance | |
| If you need help recovering or have other special health needs | Home health care | 40% coinsurance | 50% coinsurance | Calendar year maximum of 140 visits for out-of-network providers . |
| | Rehabilitation services | \$80 copay /visit outpatient, no deductible . 40% coinsurance inpatient | 50% coinsurance | Calendar year maximum of 30 days for inpatient and 30 sessions for outpatient rehabilitation and habilitation. May be eligible for additional days or sessions for head or spinal cord injury. Limits apply separately to rehabilitative and habilitative services. Prior authorization may be required. Failure to obtain prior authorization results in denial. |
| | Habilitation services | \$80 copay /visit outpatient, no deductible . 40% coinsurance inpatient | 50% coinsurance | |
| | Skilled nursing care | 40% coinsurance | 50% coinsurance | Calendar year maximum of 60 visits. |

| 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) | |
| | Durable medical equipment | 40% coinsurance ; 67% coinsurance for wigs | 50% coinsurance ; 67% coinsurance for wigs | Includes supplies and prosthetics. Wheelchairs subject to frequency limits. Wigs are covered once per year for hair loss resulting from chemotherapy or radiation therapy. Prior authorization may be required. Failure to obtain prior authorization results in denial. |
| | Hospice services | 40% coinsurance | 50% coinsurance | Hospice coverage includes respite care limits of 5 consecutive days and a lifetime maximum of 30 days. |
| If your child needs dental or eye care | Children's eye exam | \$40 copay /visit, no deductible | 50% coinsurance | Limited to one eye exam per calendar year for children under age 19. Additional in-network preventive eye screening for children age 3-5 at no cost sharing. |
| | Children's glasses | 40% coinsurance , no deductible | 50% coinsurance | Covers one pair of glasses per calendar year, 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 .) | | |
|--|--|--|
| <ul style="list-style-type: none"> Bariatric Surgery Cosmetic Surgery, except as required for certain situations Dental Care except for accident related injuries | <ul style="list-style-type: none"> Infertility Treatment Long Term Care Naturopathic Substances Non-emergency care when traveling outside the U.S. | <ul style="list-style-type: none"> 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.) | | |
| <ul style="list-style-type: none"> Acupuncture | <ul style="list-style-type: none"> Chiropractic Care | <ul style="list-style-type: none"> Hearing Aids |

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 Oregon Division of Financial Regulation at 1-888-877-4894 or www.dfr.oregon.gov 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 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 1-888-217-2363. 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 Oregon Division of Financial Regulation at 1-888-877-4894 or www.dfr.oregon.gov.

Does this plan provide Minimum Essential Coverage? Yes.

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet 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): Dinek'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.*—————

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 | \$3,000 |
| ■ Specialist copayment | \$80 |
| ■ Hospital (facility) coinsurance | 40% |
| ■ Other coinsurance | 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*)

| | |
|---------------------------|-----------------|
| Total Example Cost | \$12,800 |
|---------------------------|-----------------|

In this example, Peg would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| Deductibles | \$3,000 |
| Copayments | \$40 |
| Coinsurance | \$3,800 |
| What isn't covered | |
| Limits or exclusions | \$300 |
| The total Peg would pay is | \$7,140 |

Managing Joe's type 2 Diabetes

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

| | |
|---|---------|
| ■ The plan's overall deductible | \$3,000 |
| ■ Specialist copayment | \$80 |
| ■ Hospital (facility) coinsurance | 40% |
| ■ Other coinsurance | 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*)

| | |
|---------------------------|----------------|
| Total Example Cost | \$7,400 |
|---------------------------|----------------|

In this example, Joe would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| Deductibles | \$1,700 |
| Copayments | \$1,900 |
| Coinsurance | \$50 |
| What isn't covered | |
| Limits or exclusions | \$60 |
| The total Joe would pay is | \$3,710 |

Mia's Simple Fracture

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

| | |
|---|---------|
| ■ The plan's overall deductible | \$3,000 |
| ■ Specialist copayment | \$80 |
| ■ Hospital (facility) coinsurance | 40% |
| ■ Other coinsurance | 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*)

| | |
|---------------------------|----------------|
| Total Example Cost | \$1,900 |
|---------------------------|----------------|

In this example, Mia would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| Deductibles | \$1,500 |
| Copayments | \$300 |
| Coinsurance | \$30 |
| What isn't covered | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$1,830 |

Moda does not discriminate

Moda, Inc. follows 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, 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 Nessler-Cass coordinates our nondiscrimination work:

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

