



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:
What is the overall deductible ?	For network providers \$9,000 individual / \$18,000 family. Out-of-network providers are not covered.	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. For example: In-network office visits for primary care, specialist and urgent care , virtual care visits, most preventive care , office visits for outpatient behavioral health services, outpatient rehabilitation services , and habilitation services , in and out-of-network Value and Select tier prescription medications, in-network children's routine eye exams and glasses, adult eye exams, and hearing 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 \$12,000 individual / \$24,000 family. Out-of-network providers are not covered.	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, expenses incurred due to brand substitution and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .

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	\$80 copay /office visit, \$10 copay /virtual care visit, No charge for CirrusMD virtual visit; Deductible does not apply	Not Covered	None
	Specialist visit	\$135 copay /office visit, \$80 copay /acupuncture and spinal manipulation visit, \$10 copay /virtual care visit, No charge for CirrusMD virtual visit; Deductible does not apply	Not Covered	Office visits by naturopaths, acupuncturists and chiropractors are specialist visits. Preauthorization may be required. Failure to get preauthorization results in denial.
	Preventive care/screening /immunization	No charge for most services. \$80 copay /visit, deductible does not apply or 20% coinsurance for remaining services.	Not Covered	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)	20% coinsurance	Not Covered	Includes other tests such as EKG, allergy testing and sleep study.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	Not Covered	Preauthorization may be required. Failure to get preauthorization 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	\$15 copay /retail prescription, \$45 copay /90-day retail and mail order prescription; deductible does not apply	\$15 copay /retail prescription, deductible does not apply	Preauthorization may be required. Covers up to a 30-day supply (retail pharmacy) and 90-day supply (mail order and participating retail pharmacies). Mail order at a Moda Health designated mail order pharmacy only. Covers up to a 30-day supply for most specialty medications. Moda Health designated specialty pharmacy only. Anticancer medication is covered at 20% coinsurance Maximum cost sharing for insulin is \$35 for 30-day supply and \$105 for 90-day supply, deductible does not apply.
	Select tier	\$15 copay /retail prescription, \$45 copay /90-day retail and mail order prescription; deductible does not apply	\$15 copay /retail prescription, deductible does not apply	
	Preferred tier	40% coinsurance	40% coinsurance	
	Non-preferred tier	50% coinsurance	50% coinsurance	
	Specialty drug tier	45% coinsurance preferred specialty prescription. 50% coinsurance non-preferred specialty prescription.	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Not Covered	Preauthorization may be required. Failure to get preauthorization results in denial.
	Physician/surgeon fees	20% coinsurance	Not Covered	
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	None
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	\$135 copay /office visit, \$10 copay /virtual care visit, No charge for CirrusMD virtual visit; Deductible does not apply	Not Covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Not Covered	Preauthorization may be required. Failure to get preauthorization results in denial.
	Physician/surgeon fees	20% coinsurance	Not Covered	

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 mental health, behavioral health, or substance abuse services	Outpatient services	\$80 copay /office visits and intensive outpatient visits, deductible does not apply, \$10 copay /virtual care visit, deductible does not apply, No charge for CirrusMD virtual visit, 20% coinsurance for other outpatient services	Not Covered	Preauthorization may be required. Failure to get preauthorization results in denial.
	Inpatient services	20% coinsurance	Not Covered	Preauthorization may be required. Failure to get preauthorization results in denial.
If you are pregnant	Office visits	No charge	Not Covered	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	20% coinsurance	Not Covered	
	Childbirth/delivery facility services	20% coinsurance	Not Covered	

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	20% coinsurance	Not Covered	None
	Rehabilitation services	\$135 copay /outpatient visit, deductible does not apply. 20% coinsurance for inpatient	Not Covered	Calendar Year maximum of 30 sessions for outpatient rehabilitation and habilitation; and up to 60 rehabilitation sessions to treat neurologic conditions. Calendar Year maximum of 30 days for inpatient rehabilitation and habilitation or 60 days rehabilitation for head or spinal cord injury. Limits apply separately to rehabilitative and habilitative services. Preauthorization may be required. Failure to get preauthorization results in denial.
	Habilitation services	\$135 copay /outpatient visit, deductible does not apply. 20% coinsurance for inpatient	Not Covered	
	Skilled nursing care	20% coinsurance	Not Covered	Limited to 60 days per calendar year.
	Durable medical equipment	20% coinsurance 67% coinsurance for wigs	Not Covered	Includes supplies and prosthetics. Frequency limits apply to some durable medical equipment (DME). Wigs are covered once per year for hair loss resulting from chemotherapy or radiation therapy. Preauthorization may be required. Failure to get preauthorization results in denial.
	Hospice services	20% coinsurance	Not Covered	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	No charge	Not Covered	Limited to 1 per year.
	Children's glasses	No charge	Not Covered	Coverage limited to 1 pair of glasses per 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](#).)

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|-------------------------|--|------------------------|
| • Bariatric surgery | • Long-term care | • Private-duty nursing |
| • Cosmetic surgery | • Naturopathic supplies | • 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, limited to 20 visits per calendar year | • Routine eye care (Adult), limited to one eye exam per year |
| • Acupuncture, limited to 12 visits per calendar year | • Hearing aids, limited to one per ear every 3 years | |

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 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 1-888-217-2363. 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

[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): 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	\$9,000
■ Specialist copayment	\$135
■ 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
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$9,000
Copayments	\$10*
Coinsurance	\$700*
What isn't covered	
Limits or exclusions	\$50
The total Peg would pay is	\$9,760*

Managing Joe's Type 2 Diabetes

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

■ The plan's overall deductible	\$9,000
■ Specialist copayment	\$135
■ 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
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$4,500
Copayments	\$700
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$5,220

Mia's Simple Fracture

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

■ The plan's overall deductible	\$9,000
■ Specialist copayment	\$135
■ 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
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$2,300
Copayments	\$400
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$2,700

*Note: These numbers assume a global charge. If your provider bills each service separately, these amounts may be different.

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