



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 and out-of-network providers \$200 individual / \$400 family in a calendar year.</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, virtual care visits, urgent care visit, outpatient rehabilitation, outpatient mental health and chemical dependency services, chiropractic care, outpatient diagnostic x-rays and labs, biofeedback, breastfeeding support, tobacco cessation treatment, and most preventive care, as well as in and out of network emergency room care, prescription medication, 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>Maximum Medical Responsibility: For network providers \$500 individual / \$1,000 family in a calendar year; for out-of-network providers \$2,200 individual / \$4,400 family in a calendar year. Out-of-pocket limit: For network providers \$6,600 individual / \$13,200 family in a calendar year; for out-of-network providers there is no maximum.</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, expenses incurred due to transplants not performed at a Center of Excellence, expenses incurred due to brand substitution, services performed by an out-of-network provider, 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	\$10 copay /visit, no deductible \$5 copay /visit, no deductible for virtual care visits	30% coinsurance	None
	Specialist visit	\$5 copay /visit, no deductible for virtual care visits 10% coinsurance , no deductible for chiropractic services other than spinal manipulations (x-rays, lab). \$10 copay /visit, no deductible for other visits	30% coinsurance	Includes office visits by chiropractors and naturopathic physicians. 20 visits per calendar year maximum for spinal manipulations.
	Preventive care/screening/immunization	No charge for most services. \$10 copay /visit or 10% coinsurance for remaining services. No deductible for most services.	30% 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. A list of in-network preventive services not subject to cost sharing can be viewed at https://www.healthcare.gov/coverage/preventive-care-benefits/

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 test	Diagnostic test (x-ray, blood work)	10% coinsurance , no deductible in outpatient/office setting	30% coinsurance	Includes other tests such as EKG, allergy testing and sleep study. Prior authorization is required for many services. Failure to obtain Prior authorization results in denial.
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.modahealth.com/pd/	Generic tier	\$10 copay /retail prescription, \$20 copay /Choice90 ^{Rx} and mail order prescription No deductible	\$10 copay /retail prescription No deductible	Covers up to a 30-day supply (retail pharmacy); 84 to 90-day supply (participating Choice90 ^{Rx} pharmacies) and 90 day supply (mail order pharmacy). Prior authorization may be required. Mail order at a Moda designated mail order pharmacy only. Covers up to a 30-day supply specialty. Prior authorization may be required. Moda designated pharmacy only. No cost sharing for anticancer medication.
	Brand tier	\$20 copay /retail prescription, \$40 copay /Choice90 ^{Rx} and mail order prescription No deductible	\$20 copay /retail prescription No deductible	
	Specialty tier	\$10 copay generic prescription \$20 copay brand prescription No deductible	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance	Prior authorization may be required. Failure to obtain prior authorization results in denial.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	
If you need immediate medical attention	Emergency room care	\$200 copay /visit, no deductible	\$200 copay /visit, no deductible	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	10% coinsurance , no deductible for mental health/substance abuse related services 20% coinsurance , no deductible for all other services	10% coinsurance , no deductible for mental health/substance abuse related services 20% coinsurance , no deductible for all other services	Calendar year maximum of 300 miles for services not related to mental health/substance abuse. In-network out-of-pocket limit apply.
	Urgent care	\$10 copay /visit, no deductible \$5 copay /visit, no deductible for virtual care visits	30% 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)	10% coinsurance	30% coinsurance	Prior authorization is required. Failure to obtain prior authorization results in denial.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$10 copay /office visit, no deductible . \$5 copay /visit, no deductible for virtual care visits. 10% coinsurance for other outpatient services	30% coinsurance	Prior authorization is required for some services. Failure to obtain prior authorization results in denial.
	Inpatient services	10% coinsurance	30% coinsurance	Prior authorization is required. Failure to obtain prior authorization results in denial.
If you are pregnant	Office visits	10% coinsurance	30% coinsurance	In-network elective abortion is covered at no cost sharing. Cost sharing does not apply to certain preventive services . Depending on the type of services, a copayment , coinsurance , or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	10% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	30% coinsurance	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	30% coinsurance	None.
If you need help recovering or have other special health needs	Rehabilitation services	No charge outpatient. 10% coinsurance inpatient	30% coinsurance	Calendar year maximum of 30 days for inpatient and 30 sessions for outpatient rehabilitation except as required for mental health parity. May be eligible for 60 days for inpatient and 60 sessions for outpatient rehabilitation for acute head or spinal cord injury. Habilitation services are limited to services that qualify under rehabilitation guidelines and medically necessary to treat a mental health condition. Prior authorization may be required. Failure to obtain prior authorization results in denial.
	Habilitation services	No charge outpatient. 10% coinsurance inpatient	30% coinsurance	
	Skilled nursing care	10% coinsurance	30% coinsurance	100 maximum days per stay.

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	Durable medical equipment	10% coinsurance	30% coinsurance	Includes supplies and prosthetics. Frequency limits apply to some DME. Prior authorization may be required. Failure to obtain prior authorization results in denial.
	Hospice services	10% coinsurance	30% coinsurance	Calendar year maximum of 12 days for inpatient care and 170 hours for respite care.
If your child needs dental or eye care	Eye exam	No charge	30% coinsurance	Preventive vision screening for children age 3-5 covered in-network at no cost sharing. Eye exams are not covered for other ages.
	Glasses	Not covered	Not covered	None
	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"> Acupuncture Bariatric Surgery Cosmetic Surgery, except as required for certain situations 	<ul style="list-style-type: none"> Dental Care (Adult), except for accident related injuries Infertility Treatment Long Term Care 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"> 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	\$200
■ Specialist copayment	\$10
■ Hospital (facility) coinsurance	10%
■ Other coinsurance	10%

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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$200
Copayments	\$0
Coinsurance	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$300
The total Peg would pay is	\$800

Managing Joe's type 2 Diabetes

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

■ The plan's overall deductible	\$200
■ Specialist copayment	\$10
■ Hospital (facility) coinsurance	10%
■ Other coinsurance	10%

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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$200
Copayments	\$1,000
Coinsurance	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Joe would pay is	\$1,460

Mia's Simple Fracture

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

■ The plan's overall deductible	\$200
■ Specialist copayment	\$10
■ Hospital (facility) coinsurance	10%
■ Other coinsurance	10%

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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$200
Copayments	\$200
Coinsurance	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$5000

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 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

