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 1-855-425-4543. 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 1-855-425-4543 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For Tier I (Salem Health Hospitals & Clinics and facilities): $1,600 for subscriber only coverage / $3,200 for family; for Tier II (Connexus network): $1,750 for subscriber only coverage / $3,500 for family coverage; for Tier III (Connexus network): $3,000 for subscriber only coverage / $6,000 for family coverage; most out-of-network providers are not covered. Services by Tier IV providers apply to Tier III deductible.	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, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Examples of some services: Most Tier I, Tier II and Tier III preventive care, as well as in and out of network value tier 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 Tier I: $3,200 for subscriber only coverage / $6,000 for family; for Tier II: $4,000 for subscriber only coverage / $8,000 for family; for Tier III: $6,000 for subscriber only coverage / $12,000 for family; most out-of-network providers are not covered. Services by Tier IV providers apply to Tier III out-of-pocket limit.	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, the overall family out-of-pocket limit must be 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 1-855-425-4543 for a list of network providers.	You pay the least if you use a provider in Tier I (Salem Health Hospitals & Clinics and facilities). You pay more if you use a provider in Tier II or Tier III (Connexus 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
		Tier I Provider	Tier II Provider	Tier II Provider	Tier IV (Out-of-Network) Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	0% coinsurance	20% coinsurance	40% coinsurance	Not covered	None.
	Specialist visit	0% coinsurance	20% coinsurance	20% coinsurance for acupuncture, spinal manipulation and massage therapy 40% coinsurance for all other visits	20% coinsurance for acupuncture, spinal manipulation and massage therapy Not covered for all other visits	Includes office visits by chiropractors, naturopathic physicians and acupuncturists. 20 visits per calendar year maximum for acupuncture care. 20 visits per calendar year maximum for spinal manipulations. $1,000 per calendar year maximum for massage therapy.
	Preventive care / screening / immunization	0% coinsurance for tobacco supplies No charge for other services	20% coinsurance for tobacco supplies No charge for other services	20% coinsurance for tobacco supplies No charge for other 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)	0% coinsurance	20% coinsurance	40% coinsurance	Not covered	Includes other tests such as EKG, allergy testing and sleep study.
	Imaging (CT/PET scans, MRIs)	0% coinsurance	20% coinsurance	40% coinsurance	Not covered	Prior authorization is required for many services. Failure to get prior authorization results in denial.

* 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
		Tier I Provider	Tier II Provider	Tier III (Out-of-Network) Provider	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.modahealth.com/pdl	Value	$2 copay for 30-day supply retail $6 copay for 90-day supply retail and mail order No deductible	$2 copay for 30-day supply retail No deductible	$2 copay for 30-day supply retail No deductible	Tier I - Salem Health and mail order pharmacies Tier II - ArrayRx Core Network Tier III – other retail pharmacies Covers Tier I retail and mail order - up to a 90-day supply per prescription; Tier II and Tier III retail - up to a 30-day supply per prescription. 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. Cost Sharing for anticancer medication is same as any other medication. $85 maximum cost share 30-day supply and $255 maximum cost share 90-day supply for insulin, deductible does not apply.
	Select	25% coinsurance $5 minimum $25 maximum per prescription retail and mail order	35% coinsurance $15 minimum / $25 maximum per prescription retail	50% coinsurance $15 minimum / no maximum per prescription retail	
	Preferred	30% coinsurance $5 minimum $75 maximum per prescription retail and mail order	40% coinsurance $15 minimum / no maximum per prescription retail	50% coinsurance $15 minimum / no maximum per prescription retail	
	Non-Preferred	50% coinsurance $5 minimum / no maximum per prescription retail and mail order	50% coinsurance $15 minimum / no maximum per prescription retail	50% coinsurance $15 minimum / no maximum per prescription retail	
	Specialty	25% coinsurance $5 minimum / $25 maximum for select 30% coinsurance $150 maximum per prescription for preferred; 50% coinsurance for non-preferred	Not covered	Not covered	

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Tier I Provider	Tier II Provider	Tier III Provider	Tier IV (Out-of-Network) Provider	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	20% coinsurance	40% coinsurance	Not covered	Prior authorization may be required. Failure to get prior authorization results in denial.
	Physician/surgeon fees	0% coinsurance	20% coinsurance	40% coinsurance	Not covered	
If you need immediate medical attention	Emergency room care	Facility fee: 20% coinsurance Provider fee: 0% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	None.
	Emergency medical transportation	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	None.
	Urgent care	0% coinsurance	0% coinsurance for mental health or substance use disorder services 20% coinsurance for all other services	0% coinsurance for mental health or substance use disorder services 40% coinsurance for all other services	0% coinsurance for mental health or substance use disorder services 40% coinsurance for all other services	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	20% coinsurance	40% coinsurance	Not covered	Prior authorization is required for many services. Failure to obtain prior authorization results in denial.
	Physician/surgeon fees	0% coinsurance	20% coinsurance	40% coinsurance	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% coinsurance	0% coinsurance for office visits 20% coinsurance for other outpatient services.	0% coinsurance for office visits 20% coinsurance for other outpatient services.	0% coinsurance for office visits 40% coinsurance for other outpatient services.	Plan coinsurance may apply to some services.
	Inpatient services	0% coinsurance	0% coinsurance for Residential Treatment Programs 20% coinsurance for all other services	0% coinsurance for Residential Treatment Programs 20% coinsurance for all other services	40% coinsurance	Prior authorization is required. Failure to obtain prior authorization results in denial.

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Tier I Provider	Tier II Provider	Tier III Provider	Tier IV (Out-of-Network) Provider	
If you are pregnant	Office visits	0% coinsurance	20% coinsurance	40% coinsurance	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	0% coinsurance	20% coinsurance	40% coinsurance	Not covered	
	Childbirth/delivery facility services	0% coinsurance	20% coinsurance	40% coinsurance	Not covered	
If you need help recovering or have other special health needs	Home health care	0% coinsurance	20% coinsurance	20% coinsurance	Not covered	Calendar year maximum of 100 visits.
	Rehabilitation services	0% coinsurance	20% coinsurance	40% coinsurance	Not covered	Calendar year maximum of 60 visits each for physical therapy, occupational therapy and speech and hearing therapy except for treating mental health conditions. Services for neurodevelopmental disorders or developmental delays related to a neurogenic condition are covered. Prior authorization may be required. Failure to obtain prior authorization results in denial.
	Habilitation services	0% coinsurance	20% coinsurance	40% coinsurance	Not covered	
	Skilled nursing care	N/A	20% coinsurance	20% coinsurance	Not covered	Calendar year maximum of 120 days
	Durable medical equipment	0% coinsurance	20% coinsurance	20% coinsurance	Not covered	Includes supplies and prosthetics. Prior authorization may be required. Failure to obtain prior authorization results in denial.
	Hospice services	0% coinsurance	20% coinsurance	20% coinsurance	Not covered	None.
If your child needs dental or eye care	Children's eye exam	No charge	No charge	No charge	Not covered	Preventive vision exam limited for children age 3-5. Eye exams are not covered for other ages.
	Children's glasses	Not covered	Not covered	Not covered	Not covered	None.
	Children's dental check-up	Not covered	Not covered	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.)

- Cosmetic surgery, except as required for certain situations
- Dental care (Adult), except for accident related injuries
- Infertility treatment (except for diagnostic visits)
- Long-term care
- Naturopathic supplies
- Non-emergency care when traveling outside the U.S.
- 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.)

- Abortion
- Acupuncture
- Bariatric surgery
- Chiropractic care
- 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 1-855-425-4543. 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.**
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, kwiijigo 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	$1,750
Specialist coinsurance	20%
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	$1,750
Copayments	$0
Coinsurance	$2,200
What isn't covered	
Limits or exclusions	$50
The total Peg would pay is	**$4,000**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$1,750
Specialist coinsurance	20%
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	$1,700
Copayments	$60
Coinsurance	$1,300
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$3,080**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$1,750
Specialist coinsurance	20%
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	$1,750
Copayments	$0
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,950**

The plan would be responsible for the other costs of these EXAMPLE covered services.

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact your group administrator.

Nondiscrimination notice

We follow federal civil rights laws. We do not discriminate based on race, religion, 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:

Medicare Customer Service,
877-299-9062 (TDD/TTY 711)

Medicaid Customer Service,
888-788-9821 (TDD/TTY 711)

Customer Service for all other plans,
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.

Scott White coordinates our nondiscrimination work:

Scott White,
Compliance Officer
601 SW Second Ave.
Portland, OR 97204
855-232-9111
compliance@modahealth.com

modahealth.com

2688-NDS-MH+DD-Generic (06/23)

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 1-877-605-3229 (الهاتف النصي: 711)

توجہ دیں: اگر آپ اردو (URDU) بولتے ہیں تو لسانی اعانت آپ کے لیے بلا معاوضہ دستیاب ہے۔ پر کال کریں 1-877-605-3229 (TTY: 711)

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)

توجه: در صورتی که به فارسی صحبت می کنید، خدمات ترجمه به صورت رایگان برای شما موجود است. با 1-877-605-3229 (TTY: 711) 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 Sprachassistenzdienste 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（TYY、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。

અગત્યનું: જો તમે (ભાષાંતર કરેલ ભાષા અહીં દર્શાવો) બોલો છો તો તે ભાષામાં તમારે માટે વિના મૂલ્યે સહાય ઉપલબ્ધ છે. 1-877-605-3229 (TTY: 711) પર કૉલ કરો

ໂປດຊາບ: ຖ້າທ່ານເວົ້າພາສາລາວ, ການຊ່ວຍເຫຼືອດ້ານພາສາແມ່ນມີໃຫ້ທ່ານໂດຍບໍ່ເສັຍຄ່າ. 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)

HUBACHIISA: 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)