**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 and out-of-network providers $5,000 individual / $10,000 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. Examples of some services: In-network office visits for primary care, specialist and urgent care, virtual care visits, preventive care, office visits for outpatient behavioral health services, outpatient diagnostic test, outpatient rehabilitation services and habilitation services, as well as most in and out of network vision services and prescription 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 network providers $8,500 individual / $17,000 family; for out-of-network providers $8,500 individual / $17,000 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, 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. |
| **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. |

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **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 | $5 copay/first 3 in person or virtual visits, then $35 copay/office visit and virtual care visit<br>No charge/CirrusMD virtual visit; deductible does not apply | 50% coinsurance | First 3 visits combined with virtual care, naturopathic physicians, mental health or substance use disorder office visits. |
| | Specialist visit | $35 copay/visit for acupuncture and spinal manipulation,<br>$35 copay/virtual care visit,<br>$60 copay/visit for other visits,<br>No charge/CirrusMD virtual visit; deductible does not apply. | 50% coinsurance | Office visits by chiropractors and acupuncturists are specialist visits. Preauthorization may be required. Failure to get preauthorization results in denial. |
| | Preventive care / screening / immunization | No charge for most services. 30% coinsurance, deductible does not apply for remaining services. | Not covered for most services. 50% coinsurance for remaining services. | 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) | 30% coinsurance; deductible does not apply to outpatient / office setting | 50% coinsurance | Includes other tests such as EKG, allergy testing and sleep study. |
| | Imaging (CT/PET scans, MRIs) | 30% coinsurance | 50% coinsurance | 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 | $5 copay/retail prescription, $10 copay/90-day retail and mail order prescription; deductible does not apply | $5 copay/retail prescription, deductible does not apply | Preauthorization may be required.<br><br>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.<br><br>Covers up to a 30-day supply for most specialty. Moda Health designated pharmacy only.<br><br>$35 maximum cost share 30-day supply and $105 maximum cost share 90-day supply for insulin, deductible does not apply.<br><br>Cost sharing for anticancer medication is 30% coinsurance. |
| | Select tier | $10 copay/retail prescription, $20 copay/90-day retail and mail order prescription; deductible does not apply | $10 copay/retail prescription, deductible does not apply | |
| | Preferred tier | $50 copay/retail prescription, $100 copay/90-day retail and mail order prescription; deductible does not apply | $50 copay/retail prescription, deductible does not apply | |
| | Non-preferred tier | $75 copay/retail prescription, $150 copay/90-day retail and mail order prescription; deductible does not apply | $75 copay/retail prescription, deductible does not apply | |
| | Specialty drug tier | 30% coinsurance; deductible does not apply | Not covered | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 30% coinsurance | 50% coinsurance | Preauthorization may be required. Failure to get preauthorization results in denial. |
| | Physician/surgeon fees | 30% coinsurance | 50% coinsurance | |
| **If you need immediate medical attention** | Emergency room care | $250 copay/visit, then 30% coinsurance, deductible does not apply | $250 copay/visit, then 30% coinsurance, deductible does not apply | 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 | 30% coinsurance | 30% coinsurance | In-network out-of-pocket limit apply. |
| | Urgent care | $60 copay/office visit.<br>$35 copay/virtual care visit,<br>No charge/ CirrusMD virtual visit; deductible does not apply. | 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) | 30% coinsurance | 50% coinsurance | Preauthorization may be required. Failure to get preauthorization results in denial. |
| | Physician/surgeon fees | 30% coinsurance | 50% coinsurance | |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $5 copay/first 3 in person or virtual visits, then $35 copay/office, intensive outpatient, and virtual care visit; No charge/ CirrusMD virtual visit; deductible does not apply.<br>30% coinsurance for other outpatient services. | 50% coinsurance | First 3 visits combined with virtual care, PCP and naturopathic physicians office visits.<br><br>Preauthorization may be required. Failure to get preauthorization results in denial. |
| | Inpatient services | 30% coinsurance | 50% coinsurance | Preauthorization may be required. Failure to get preauthorization results in denial. |
| **If you are pregnant** | Office visits | No charge | 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 | 30% coinsurance | 50% coinsurance | |
| | Childbirth/delivery facility services | 30% coinsurance | 50% coinsurance | |
| **If you need help recovering or have other special health needs** | Home health care | 30% coinsurance | 50% coinsurance | Limited to 140 visits per calendar year. |
| | Rehabilitation services | $60 copay/outpatient visit, deductible does not apply.<br>30% coinsurance for inpatient | 50% 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. Preauthorization may be required. Failure to obtain preauthorization results in denial. |
| | Habilitation services | $60 copay/outpatient visit, deductible does not apply.<br>30% coinsurance for inpatient | 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** | Skilled nursing care | 30% coinsurance | 50% coinsurance | Limited to 60 days per calendar year. |
| | Durable medical equipment | 30% coinsurance | 50% coinsurance | Includes supplies and prosthetics. Frequency limits apply to some durable medical equipment (DME). Preauthorization may be required. Failure to obtain preauthorization results in denial. |
| | Hospice services | 30% coinsurance | 50% coinsurance | Calendar year maximum of 12 days for inpatient care and 170 hours for respite care. |
| **If your child needs dental or eye care** | Children's eye exam | No charge | No charge | Vision exam and supplies paid once every calendar year for members under age 19. Additional vision screening covered in-network under preventive care for children age 3 to 5. $400 every calendar year for members age 19 and over for combined vision services. |
| | Children's glasses | No charge | No charge | |
| | 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.)**

- Bariatric surgery
- Cosmetic surgery, except as required for certain situations
- Dental care (Adult), except for accident related injuries
- Infertility treatment
- Long-term care
- Naturopathic supplies
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- 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, limited to 12 visits per year
- Chiropractic care, limited to 20 visits per year
- Hearing aids, one per ear every 3 years
- 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, 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.

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

**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.**
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 | $5,000 |
| Specialist copayment | $60 |
| Hospital (facility) coinsurance | 30% |
| Other coinsurance | 30% |

**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 | $5,000 |
| Copayments | $10* |
| Coinsurance | $2,300* |
| *What isn't covered* | |
| Limits or exclusions | $50 |
| **The total Peg would pay is** | **$7,360*** |

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

| | |
|---|---|
| The plan's overall deductible | $5,000 |
| Specialist copayment | $60 |
| Hospital (facility) coinsurance | 30% |
| Other coinsurance | 30% |

**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 | $200 |
| Copayments | $1,600 |
| Coinsurance | $40 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$1,860** |

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

| | |
|---|---|
| The plan's overall deductible | $5,000 |
| Specialist copayment | $60 |
| Hospital (facility) coinsurance | 30% |
| Other coinsurance | 30% |

**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 | $1,500 |
| Copayments | $500 |
| Coinsurance | $200 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$2,200** |

*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.