

# STOP! Read this first.

Much of the information contained in the enclosed **Summary of Benefits and Coverage** (SBC) does not directly apply to your health reimbursement arrangement (HRA). SBCs are mandated by federal health care reform to help consumers understand and compare health insurance plans. While your HRA is a group health plan, it is not insurance. Some of the information and defined terms in the enclosed SBC are not applicable to your HRA.

When reading through the enclosed SBC, keep in mind:

- **Your HRA is not an insurance plan. It is an account you can use to reimburse your qualified out-of-pocket medical care expenses.**
- **Your HRA is funded with employer contributions, which may include mandatory salary reductions.**
- **With your HRA, you do not have co-pays or deductibles, and you do not pay a premium for HRA coverage unless you have elected COBRA continuation of coverage. However, you can use funds in your HRA to reimburse these types of qualified expenses if your HRA is claims-eligible.**
- **Qualified expenses for your Garner HRA, as defined by the IRS, include services received from any Garner “top” provider.**
- **Your maximum benefit (reimbursement) amount from the Garner HRA is \$700 for self-only coverage or \$1,400 for family coverage, up to your available HRA account balance at the time your claim is processed.**

To learn more about your Garner HRA Plan benefits, your best resource is the [Garner HRA Plan Summary](#). To get a copy, log in at [website](#) and click [Resources](#), or contact the Garner HRA concierge team by calling 458-488-4828.



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](http://www.modahealth.com) or by calling 1-1-866-923-0409. 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 <https://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 <a href="#">deductible</a> ?	For <a href="#">network providers</a> \$1,900 coordinated care individual / \$2,000 non-coordinated care individual / \$4,000 family; for <a href="#">out-of-network providers</a> \$3,500 individual / \$7,000 family.	Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the policy, the overall family <a href="#">deductible</a> must be met before the <a href="#">plan</a> begins to pay.
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. Examples of some services: In-network breastfeeding support, tobacco cessation treatment, and most <a href="#">preventive care</a> , as well as in and out of network value medications and breastfeeding supplies, are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	For <a href="#">network providers</a> \$7,300 coordinated care individual / \$7,650 non-coordinated care individual / \$15,300 family; for <a href="#">out-of-network providers</a> \$14,000 individual / \$28,000 family.	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, transplants and bariatric surgery not performed at Center of Excellence facilities, out-of-pocket expenses in excess of the reference price for an oral appliance or hip and knee replacements, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.modahealth.com">www.modahealth.com</a> or call 1-866-923-0409 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

\* For more information about limitations and exceptions, see the [plan](#) document, which is accessible via the Garner Health website, concierge, or smartphone app.



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		Out-of-Network Provider (You will pay the most)	
		Coordinated Care (You will pay the least)	Non-Coordinated Care		
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	15% <a href="#">coinsurance</a>  \$10 <a href="#">copay</a> /visit, for virtual care visits	20% <a href="#">coinsurance</a>  \$10 <a href="#">copay</a> /visit, for virtual care visits	50% <a href="#">coinsurance</a>	0% coinsurance/CirrusMD virtual visit
	<a href="#">Specialist</a> visit	20% <a href="#">coinsurance</a> for acupuncture, spinal manipulation and naturopathic substances.  15% <a href="#">coinsurance</a> for remaining services.	25% <a href="#">coinsurance</a> for acupuncture, spinal manipulation and naturopathic substances.  20% <a href="#">coinsurance</a> for remaining services	50% <a href="#">coinsurance</a>	0% coinsurance/CirrusMD virtual visit  Includes office visits by chiropractors, naturopathic physicians and acupuncturists. Limited to 12 visits per plan year for acupuncture care and spinal manipulation.
	<a href="#">Preventive care/screening/immunization</a>	No charge for most services. 15% or 20% <a href="#">coinsurance</a> for remaining services.	No charge for most services. 20% or 25% <a href="#">coinsurance</a> for remaining services.	50% <a href="#">coinsurance</a>	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Includes other tests such as EKG, allergy testing and sleep study. Some services require a \$100 <a href="#">copay</a> .
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Prior authorization</a> is required for many services. Failure to obtain <a href="#">prior authorization</a> results in denial

For more information about limitations and exceptions, see the [plan](#) document, which is accessible via the Garner Health website, concierge, or smartphone app.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Network Provider		Out-of-Network Provider (You will pay the most)	
		Coordinated Care (You will pay the least)	Non-Coordinated Care		
<b>If you need drugs to treat your illness or condition</b> More information about <a href="http://www.modahealth.com/pdl">prescription drug coverage</a> is available at <a href="http://www.modahealth.com/pdl">www.modahealth.com/pdl</a>	Value tier	\$4 <a href="#">copay</a> /retail, \$8 <a href="#">copay</a> /mail-order, and \$12 <a href="#">copay</a> /90-day retail prescription	\$4 <a href="#">copay</a> /retail, \$8 <a href="#">copay</a> /mail-order, and \$12 <a href="#">copay</a> /90-day retail prescription	\$4 <a href="#">copay</a> /retail prescription	No <a href="#">deductible</a> .  Covers up to a 31-day supply (retail pharmacy); and 90-day supply (mail order and participating retail pharmacies). <a href="#">Prior authorization</a> may be required. Mail order at Moda designated mail order pharmacy only.
	Select tier	20% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a>	Covers up to a 31-day supply for most specialty medications. <a href="#">Prior authorization</a> may be required. Moda designated pharmacy only.  High-cost non-preferred medications are excluded unless a formulary exception is requested and approved.  Anticancer medication is covered at no charge for in-network providers.
	Preferred tier	20% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a>	
	Nonpreferred tier	20% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a>	
	Specialty tier	20% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a>	Not covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Prior authorization</a> may be required. Failure to obtain <a href="#">prior authorization</a> results in denial.
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	

For more information about limitations and exceptions, see the [plan](#) document, which is accessible via the Garner Health website, concierge, or smartphone app.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Network Provider		Out-of-Network Provider (You will pay the most)	
		Coordinated Care (You will pay the least)	Non-Coordinated Care		
If you need immediate medical attention	<a href="#">Emergency room care</a>	20% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a> for Coordinated Care and 25% <a href="#">coinsurance</a> for Non-Coordinated Care	In-network <a href="#">deductible</a> and <a href="#">out-of-pocket limit</a> applies.
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a> for Coordinated Care and 25% <a href="#">coinsurance</a> for Non-Coordinated Care	In-network <a href="#">deductible</a> and <a href="#">out-of-pocket limit</a> apply.
	<a href="#">Urgent care</a>	15% <a href="#">coinsurance</a> \$10 <a href="#">copay</a> /visit, for virtual care visits	20% <a href="#">coinsurance</a> \$10 <a href="#">copay</a> /visit, for virtual care visits	20% <a href="#">coinsurance</a>	In-network <a href="#">deductible</a> and <a href="#">out-of-pocket limit</a> applies to mental health and chemical dependency services. 0% coinsurance/CirrusMD virtual visit
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Prior authorization</a> is required. Failure to obtain <a href="#">prior authorization</a> results in denial.
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	15% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	0% coinsurance/CirrusMD virtual visit <a href="#">Prior authorization</a> is required for some services. Failure to obtain <a href="#">prior authorization</a> results in denial.
	Inpatient services	15% <a href="#">coinsurance</a> for substance abuse services and 20% <a href="#">coinsurance</a> for other services	20% <a href="#">coinsurance</a> for substance abuse services and 25% <a href="#">coinsurance</a> for other services	50% <a href="#">coinsurance</a>	<a href="#">Prior authorization</a> is required. Failure to obtain <a href="#">prior authorization</a> results in denial.
If you are pregnant	Office visits	20% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Cost sharing</a> does not apply to certain <a href="#">preventive services</a> . Depending on the type of services, a <a href="#">copay</a> , <a href="#">coinsurance</a> , or <a href="#">deductible</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	20% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	

For more information about limitations and exceptions, see the [plan](#) document, which is accessible via the Garner Health website, concierge, or smartphone app.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Network Provider		Out-of-Network Provider (You will pay the most)	
		Coordinated Care (You will pay the least)	Non-Coordinated Care		
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Plan year maximum of 140 visits.
	<a href="#">Rehabilitation services</a>	20% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Plan 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. <a href="#">Habilitation services</a> are limited to services that qualify under rehabilitation guidelines and medically necessary to treat a mental health condition. <a href="#">Prior authorization</a> may be required. Failure to obtain <a href="#">prior authorization</a> results in denial.
	<a href="#">Habilitation services</a>	20% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
If you need help recovering or have other special health needs	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Plan year maximum of 60 days
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Includes supplies and prosthetics. Frequency limits apply to some DME. <a href="#">Prior authorization</a> may be required. Failure to obtain <a href="#">prior authorization</a> results in denial.
	<a href="#">Hospice services</a>	20% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None.
If your child needs dental or eye care	Children's eye exam	No charge	No charge	Not covered	Limited to in-network preventive vision screening for children age 3-5. Eye exams are not covered for other ages.
	Children's glasses	Not covered	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	Not covered	None

### Excluded Services & Other Covered Services:

For more information about limitations and exceptions, see the [plan](#) document, which is accessible via the Garner Health website, concierge, or smartphone app.

**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
- Long Term Care
- Private Duty Nursing
- Routine Eye Care (Adult)
- Routine Foot Care, except for diabetes
- Weight Loss Programs, except for WW

**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
- Infertility Treatment
- Naturopathic supplies
- Non-emergency care when traveling outside the U.S.

**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](http://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](http://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](http://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 1-866-923-0409. 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](http://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](http://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.* —————



**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](#) **\$1,900**
- Specialist [coinsurance](#) **15%**
- 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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
<b>In this example, Peg would pay:</b>	
<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$1,900
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$2,100
<i>What isn't covered</i>	
Limits or exclusions	\$50
<b>The total Peg would pay is</b>	<b>\$4,050</b>

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

- The [plan's](#) overall [deductible](#) **\$1,900**
- Specialist [coinsurance](#) **15%**
- 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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
<b>In this example, Joe would pay:</b>	
<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$1,900
<a href="#">Copayments</a>	\$100
<a href="#">Coinsurance</a>	\$700
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$2,720</b>

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

- The [plan's](#) overall [deductible](#) **\$1,900**
- Specialist [coinsurance](#) **15%**
- 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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
<b>In this example, Mia would pay:</b>	
<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$1,900
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,100</b>

The total patient would pay amount assumes the patient is not using funds from the Health Reimbursement Account (HRA). Account balances may provide you with funds to help cover out-of-pocket expenses. An HRA is not insurance. It is funded with employer contributions.