



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 \$250 individual / \$750 family; for out-of-network providers \$500 individual / \$1,500 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 the first four primary care, virtual care visits, preventive care , office visits for outpatient behavioral health services, chronic condition visits, and diabetes services, maternity professional services, nutritional therapy, breastfeeding support, as well as in and out of network hospice care, diabetic supplies, and breastfeeding supplies 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?	Yes. \$50 individual / \$150 family for generic and brand prescription drugs.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan ?	For network providers \$1,900 individual / \$5,700 family; for out-of-network providers \$4,800 individual / \$14,400 family ; \$1,000 individual / \$3,000 family for prescription drugs. Maximum cost share: for network providers \$6,850 individual / \$13,700 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 .

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% coinsurance at OHS Certified Primary Care Homes 15% coinsurance deductible does not apply to first 4 visits No charge for chronic condition or virtual visits No charge/CirrusMD virtual visit	30% coinsurance	None
	Specialist visit	15% coinsurance No charge/CirrusMD virtual visit	30% coinsurance	Office visits by naturopathic physicians, massage therapists, acupuncturists and chiropractors are specialist visits. \$1,000 calendar year maximum for massage therapy.
	Preventive care / screening / immunization	No charge	30% coinsurance , 15% coinsurance tobacco cessation supplies	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)	15% coinsurance	30% coinsurance	Includes other tests such as EKG, allergy testing and sleep study.
	Imaging (CT/PET scans, MRIs)	\$100 copay /per service, then 15% coinsurance	\$100 copay /per service, then 30% 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 https://www.judi.health	Value tier	No charge	No charge	See Judi Rx summary for more details
	Generic tier	\$10 copay /retail, \$25 copay /mail-order \$10 copay /specialty	\$10 copay /retail prescription	
	Brand tier	\$30 copay /retail, \$75 copay mail-order, \$100 copay and specialty	\$30 copay /retail prescription	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% coinsurance	\$100 copay /per service then 40% coinsurance	Preauthorization may be required. Failure to get preauthorization results in denial. Out-of-network bariatric surgery is not covered.
	Physician/surgeon fees	15% coinsurance	30% coinsurance	
If you need immediate medical attention	Emergency room care	\$150 copay /visit, then 15% coinsurance	\$150 copay /visit, then 15% coinsurance	In-network deductible and maximum cost share apply. Copay waived if hospital admission immediately follows.
	Emergency medical transportation	15% coinsurance	15% coinsurance	None
	Urgent care	15% coinsurance No charge/CirrusMD virtual visit	15% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	15% coinsurance	\$500 copay per admission then 40% coinsurance	Preauthorization may be required. Failure to get preauthorization results in denial. Out-of-network bariatric surgery is not covered.
	Physician/surgeon fees	15% coinsurance	30% 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 mental health, behavioral health, or substance abuse services	Outpatient services	15% coinsurance , deductible does not apply. No charge for substance use disorder	30% coinsurance	Preauthorization may be required. Failure to obtain preauthorization results in denial.
	Inpatient services	15% coinsurance No charge for substance use disorder	\$500 copay per admission then 30% coinsurance for inpatient mental health services, 40% coinsurance for other services	
If you are pregnant	Office visits	No charge	30% 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	No charge	30% coinsurance	
	Childbirth/delivery facility services	15% coinsurance	\$500 copay per admission then 40% coinsurance	
If you need help recovering or have other special health needs	Home health care	15% coinsurance	30% coinsurance	Limited to 180 visits per calendar year.
	Rehabilitation services	15% coinsurance /for outpatient; deductible does not apply. \$10 copay /visit for cardiac rehabilitation 15% coinsurance /for inpatient	30% coinsurance for outpatient; 40% coinsurance for inpatient	Calendar year maximum of 30 days for inpatient and 60 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.
	Habilitation services	15% coinsurance /for outpatient; deductible does not apply. \$10 copay /visit for cardiac rehabilitation 15% coinsurance /for inpatient	30% coinsurance for outpatient; 40% coinsurance for inpatient	Preauthorization may be required. Failure to obtain preauthorization results in denial.
	Skilled nursing care	15% coinsurance	40% coinsurance	Limited to 180 days per calendar year.
	Durable medical equipment	15% coinsurance	30% 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	No charge	No charge	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 your child needs dental or eye care	Children's eye exam	No charge	Not covered	None.
	Children's glasses	Not covered	Not covered	None.
	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 .)			
- Cosmetic surgery, except as required for certain situations - Dental care (Adult), except for accident related injuries	- 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, limited to 60 visits per year combined with spinal manipulation	- Bariatric surgery - Chiropractic care, limited to 60 visits per year combined with acupuncture	- Hearing aids, one per ear every 3 years - Infertility treatment	

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.

[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	\$250
■ Specialist coinsurance	15%
■ Hospital (facility) coinsurance	15%
■ Other coinsurance	15%

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:

<i>Cost Sharing</i>	
Deductibles	\$250
Copayments	\$200
Coinsurance	\$0

<i>What isn't covered</i>	
Limits or exclusions	\$50

The total Peg would pay is	\$500
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Managing Joe's Type 2 Diabetes

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

■ The plan's overall deductible	\$250
■ Specialist coinsurance	15%
■ Hospital (facility) coinsurance	15%
■ Other coinsurance	15%

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:

<i>Cost Sharing</i>	
Deductibles	\$200
Copayments	\$1,000
Coinsurance	\$100

<i>What isn't covered</i>	
Limits or exclusions	\$20

The total Joe would pay is	\$1,320
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Mia's Simple Fracture

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

■ The plan's overall deductible	\$250
■ Specialist coinsurance	15%
■ Hospital (facility) coinsurance	15%
■ Other coinsurance	15%

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:

<i>Cost Sharing</i>	
Deductibles	\$250
Copayments	\$500
Coinsurance	\$300

<i>What isn't covered</i>	
Limits or exclusions	\$0

The total Mia would pay is	\$1,050
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*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.