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 1-888-873-1395. 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 1-888-873-1395 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Tier 1: $3,000 individual / $6,000 family Tier 2: $6,000 individual / $12,000 family Tier 3: $12,000 individual / $24,000 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: Tier 1: outpatient diagnostic tests are covered before you meet your deductible. Tier 1 and Tier 2: office visits for primary care, specialist and urgent care, most preventive care, virtual care visits, office visits for outpatient mental health and chemical dependency, outpatient rehabilitation as well as most in and out-of-network 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?	Tier 1: $8,000 individual / $16,000 family Tier 2: $8,550 individual / $17,100 family Tier 3: $30,000 individual / $60,000 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, penalties for failure to obtain prior authorization for services, expenses incurred due to brand substitution, out-of-network benefit expenses, 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 1-888-873-1395 for a list of network providers.	You pay the least if you use a provider in Tier 1. You pay more if you use a provider in Tier 2. 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 1 Provider (You will pay the least)	Tier 2 Provider	Tier 3 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	No charge/first 3 Adult visits, then $30 copay/office visit, No charge/Child (under 19) visit, $20 copay/virtual care visit, No charge/CirrusMD virtual visit; deductible does not apply	20% coinsurance, deductible does not apply	60% coinsurance	None
	Specialist visit	$30 copay/office visit, $20 copay/virtual care visit, No charge/CirrusMD virtual visit; deductible does not apply.	20% coinsurance, deductible does not apply	60% coinsurance	Office visits by naturopaths, acupuncturists and chiropractors are considered specialist visits unless they are listed as PCPs in the network. Spinal manipulation, massage therapy and acupuncture are each limited to 24 visits per year. Prior authorization may be required for some spinal manipulation, massage therapy and acupuncture services. Failure to obtain prior authorization may result in denial or a penalty of 50% up to a maximum deduction of $2,500.
	Preventive care/screening/ immunization	No charge for most services. 20% coinsurance for remaining services, deductible does not apply.	No charge for most services, 40% coinsurance for remaining services.	60% 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.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 Provider (You will pay the least)	Tier 2 Provider	Tier 3 Provider (You will pay the most)	
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance; deductible does not apply in outpatient/office setting	40% coinsurance	60% coinsurance	Includes other tests such as EKG, allergy testing and sleep study.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	60% coinsurance	Prior authorization may be required for many services. Failure to obtain prior authorization may result in denial or a penalty of 50% up to a maximum deduction of $2,500.
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	No charge	No charge	No charge	Prior authorization may be required. Covers up to a 90-day supply for retail and mail order prescriptions. One copay for each 30-day retail supply. Mail order at a Moda Health designated mail-order pharmacy only. Covers up to a 30-day supply for most specialty. Moda Health designated pharmacy only. Cost sharing for anticancer medication is 20% coinsurance.
	Select, Preferred, and Non-preferred tiers	$15 copay or 50% coinsurance, whichever is greater, retail prescription $45 copay or 50% coinsurance, whichever is greater, 90-day retail and mail order prescription; deductible does not apply	$15 copay or 50% coinsurance, whichever is greater, retail prescription $45 copay or 50% coinsurance, whichever is greater, 90-day retail and mail order prescription; deductible does not apply	$15 copay or 50% coinsurance, whichever is greater, retail prescription; deductible does not apply	
	Specialty tier	$15 copay or 50% coinsurance, whichever is greater; deductible does not apply	$15 copay or 50% coinsurance, whichever is greater; deductible does not apply	Not covered	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 Provider (You will pay the least)	Tier 2 Provider	Tier 3 Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	60% coinsurance	Prior authorization may be required. Failure to obtain prior authorization may result in denial or a penalty of 50% up to a maximum deduction of $2,500.
	Physician/ surgeon fees	20% coinsurance	40% coinsurance	60% coinsurance	
If you need immediate medical attention	Emergency room care	$30 copay/visit, deductible does not apply	$30 copay/visit, deductible does not apply	$30 copay/visit, deductible does not apply	Copay waived if hospital admission immediately follows. Plan deductible and coinsurance may apply to some services. Tier 1 out-of-pocket limit applies.
	Emergency medical transportation	20% coinsurance	20% coinsurance	20% coinsurance	Ambulance transportation is limited to a maximum of 6 trips per calendar year. Commercial transportation is limited to one-way for a sudden, life-endangering medical condition. Tier 1 deductible and out-of-pocket limit apply.
	Urgent care	$30 copay/office visit, $20 copay/virtual care visit, No charge/CirrisMD virtual visit; deductible does not apply	20% coinsurance, deductible does not apply	60% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	60% coinsurance	Prior authorization may be required. Failure to obtain prior authorization may result in denial or a penalty of 50% up to a maximum deduction of $2,500.
	Physician/ surgeon fees	20% coinsurance	40% coinsurance	60% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 Provider (You will pay the least)	Tier 2 Provider	Tier 3 Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30 copay/office visit, $20 copay/virtual care visit; No charge/CirrusMD virtual visit; deductible does not apply. 20% coinsurance for other outpatient services.	20% coinsurance, deductible does not apply	60% coinsurance	Prior authorization may be required for some behavioral health services. Failure to obtain prior authorization may result in denial or a penalty of 50% up to a maximum deduction of $2,500.
	Inpatient services	20% coinsurance	40% coinsurance	60% coinsurance	Prior authorization may be required for inpatient and residential services. Failure to obtain prior authorization may result in denial or a penalty of 50% up to a maximum deduction of $2,500.
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	60% coinsurance	Cost sharing does not apply to certain 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	20% coinsurance	40% coinsurance	60% coinsurance	
	Childbirth/ delivery facility services	20% coinsurance	40% coinsurance	60% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	60% coinsurance	Calendar year maximum of 140 visits.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 Provider (You will pay the least)	Tier 2 Provider	Tier 3 Provider (You will pay the most)	
If you need help recovering or have other special health needs	Rehabilitation services	$30 copay/outpatient visit, deductible does not apply. 20% coinsurance for inpatient	20% coinsurance, deductible does not apply for outpatient 40% coinsurance for inpatient	60% coinsurance	Calendar year maximum of 30 days for inpatient rehabilitation and 30 sessions for outpatient rehabilitation. May be eligible for up to 60 days inpatient or up to 60 sessions for outpatient rehabilitation for head or spinal cord injury. Prior authorization may be required. Failure to obtain prior authorization may result in denial or a penalty of 50% up to a maximum deduction of $2,500.
	Habilitation services	Not covered	Not covered	Not covered	None
	Skilled nursing care	20% coinsurance	40% coinsurance	60% coinsurance	Calendar year maximum of 30 days
	Durable medical equipment	20% coinsurance	40% coinsurance	60% coinsurance	Includes items such as supplies and prosthetics. Frequency limits apply to some DME. Prior authorization may be required. Failure to obtain prior authorization may result in denial or a penalty of 50% up to a maximum deduction of $2,500.
	Hospice services	20% coinsurance	40% coinsurance	60% coinsurance	Calendar year maximum of 12 days for inpatient and 170 hours for respite care.
If your child needs dental or eye care	Children's eye exam	No charge	No charge	60% coinsurance	Limited to preventive eye 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:

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
- Dental care (Adult)
- Habilitation services
- Hearing aids
- Infertility treatment
- Long-term care
- Naturopathic substances
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- 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
- Chiropractic care

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 Alaska Division of Insurance at 1-800-467-8725 or http://www.commerce.state.ak.us/ins/Insurance/consumer.html 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 on how 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 1-888-873-1395. 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 Alaska Division of Insurance at 1-800-467-8725 or http://www.commerce.state.ak.us/ins/Insurance/consumer.html.

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 888-500-0343.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 888-500-0343.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 888-500-0343.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

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

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	$3,000
Specialist copayment	$30
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	$3,000
Copayments	$10
Coinsurance	$1,900
What isn't covered	
Limits or exclusions	$50
The total Peg would pay is	**$4,960**

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

The plan's overall deductible	$3,000
Specialist copayment	$30
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*	$200
Copayments	$200
Coinsurance	$2,100
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,520**

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

The plan's overall deductible	$3,000
Specialist copayment	$30
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*	$1,500
Copayments	$200
Coinsurance	$30
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,730**

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

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 Nesseler-Cass coordinates our nondiscrimination work:

Dave Nesseler-Cass,
Chief Compliance Officer
601 SW Second Ave.
Portland, OR 97204
855-232-9111
compliance@modahealth.com

moda HEALTH

DELTA DENTAL
Delta Dental of Oregon & Alaska

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。

modahealth.com

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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 គឺមានផ្តល់ជូនសោកអ្នក។ 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)

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DELTA DENTAL

Delta Dental of Oregon & Alaska