Moda Health Plan, Inc.: PEBB – +100 Summit Part time

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2017 – 12/31/2017

Coverage for: Individual + Family | **Plan Type:** POS

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.modahealth.com/pebb or by calling 1-844-776-1593.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-network providers: **$600** per person / **$1,800** per family. Out-of-network providers: **$1,100** per person / **$3,300** per family. Doesn't apply to in-network preventive, office visits for chronic conditions, E-visits, maternity professional services, inpatient hospital visits, outpatient mental health and chemical dependency treatment, diabetic supplies & insulin, x-ray, lab, hospice care, self-administered chemo, breastfeeding support; or prescription drugs. Copayments don't count toward the **deductible**.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes, for generic & brand prescription drugs. **$50** per person / **$150** per family.	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.
Is there an out–of–pocket limit on my expenses?	Yes. In-network providers **$2,500** per person / **$7,500** per family. Out-of-network providers **$4,500** per person / **$13,500** per family. **$1,000** per person / **$3,000** per family for prescription drugs. Maximum cost share: In-network providers **$6,850** per person / **$13,700** per family.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, deductibles, alternative care visits and services, emergency care, imaging, infertility, hearing exam & aids, sleep studies, additional cost tier, and non-essential health benefits.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See **www.modahealth.com/pebb or call 844-776-1593** for a list of in-network providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

Questions: Call 1-888-217-2363 or visit us at www.modahealth.com/pebb. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call 1-888-217-2363 to request a copy.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay/visit	50% coinsurance	First 4 in-network visits **deductible** waived. If a member does not select and properly use a medical home, claims may be paid at a lower benefit level.
	Specialist visit	$30 copay/visit	50% coinsurance	A referral by the member's medical home is required. Includes office visits by acupuncturists, chiropractors and naturopaths.
	Other practitioner office visit	$30 copay/visit alternative provider; No charge chronic conditions or E-visits	50% coinsurance; E-visits not covered.	Calendar year maximum of $1,000 for spinal manipulation and acupuncture care. Nutritional counseling up to 4 visits in a calendar year.
	Preventive care/screening / immunization	No charge	50% coinsurance	Each type of service may be subject to limitations. In-network **deductible** waived for most services.
If you have a test	Diagnostic test (x-ray, blood work)	No charge for test/ $100 copay/visit for sleep studies	50% coinsurance / $100 copay/visit, then 50% coinsurance for sleep studies	Include other tests such as EKG & allergy testing. Sleep study copay does not apply to cancer diagnosis and treatment. In-network **deductible** waived.
	Imaging (CT/PET scans, MRIs)	$100 copay/service, then 20% coinsurance	$100 copay/service, then 50% coinsurance	Prior authorization is required for many services. Failure to obtain prior authorization results in denial. Copay does not apply to cancer diagnosis and treatment.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.modahealth.com/pebb	Value drugs	No charge retail or mail-order	No charge retail	Covers up to a 30-day supply (retail and specialty prescriptions); 84 to 90-day supply (participating Choice 90 pharmacies) and 90 day supply (mail-order prescription). Prior authorization may be required. Mail order and specialty drugs at exclusive pharmacy only.
	Generic drugs	$20 copay retail, $50 copay mail order $100 copay specialty	$20 copay retail	
	Brand drugs	$50 copay retail, $125 copay mail order, $100 copay specialty	$50 copay retail	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$30 copay/visit	50% coinsurance. Bariatric surgery not covered	Prior authorization may be required. Failure to obtain prior authorization may result in denial.
	Physician/surgeon fees	$30 copay/visit	50% coinsurance	Prior authorization may be required. Failure to obtain prior authorization may result in denial. $100/$500 copay/procedure for additional cost tier.
If you need immediate medical attention	Emergency room services	$100 copay/visit	$100 copay/visit	In-network **deductible** and maximum cost sharing apply. Copay waived if covered hospitalization follows emergency room use.
	Emergency medical transportation	$75 copay/trip	$75 copay/trip	——————none——————
	Urgent care	$30 copay/visit	$30 copay/visit	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 copay per admission	50% coinsurance	Prior authorization may be required. Failure to obtain prior authorization may result in denial.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have a hospital stay (cont.)	Physician/surgeon fee	$30 copay/service	50% coinsurance	Prior authorization may be required. Failure to obtain prior authorization may result in denial. $100/$500 copay/procedure for additional cost tier
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$30 copay/visit	50% coinsurance	In-network **deductible** waived.
	Mental/Behavioral health inpatient services	$50 per day/ $250 copay per admission	50% coinsurance	Prior authorization is required for inpatient and residential services. Failure to obtain prior authorization may result in denial.
	Substance use disorder outpatient services	No charge	50% coinsurance	In-network **deductible** waived.
	Substance use disorder inpatient services	No charge	50% coinsurance	In-network **deductible** waived. Prior authorization is required for inpatient and residential services. Failure to obtain prior authorization may result in denial.
If you are pregnant	Prenatal and postnatal care	No charge	50% coinsurance	——————none——————
	Delivery and all inpatient services	$500 copay per admission	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	$30 copay/visit	50% coinsurance	Calendar year maximum of 180 visits. Prior authorization is required. Failure to obtain prior authorization may result in denial.
	Rehabilitation services	Outpatient: $30 copay per visit; inpatient: $500 copay per admission	50% coinsurance	Inpatient rehabilitation calendar year maximum of 30 days and additional 30 days for head or spinal cord injury or treatment of a stroke. Outpatient rehabilitation limited to a calendar year maximum of 60 sessions.
	Habilitation services	Outpatient: $30 copay per visit; inpatient: $500 copay per admission	50% coinsurance	

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs (continued)	Skilled nursing facility care	$50 per day/ $250 copay per admission	50% coinsurance	Calendar year maximum of 180 days.
	Durable medical equipment	20% coinsurance	50% coinsurance	Include items such as supplies and prosthetics. No charge for diabetic supplies and insulin. Prior authorization may be required. Failure to obtain prior authorization may result in denial.
	Hospice service	No charge	No charge	**Deductible** waived.
If your child needs dental or eye care	Eye exam	No Charge	Not covered	In-network **deductible** waived. Preventive eye exam limited to in-network for children age 3-5.
	Glasses	Not covered	Not covered	——————none——————
	Dental check-up	Not covered	Not covered	——————none——————

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic surgery
- Dental care (adult) except for accident-related injuries
- Long-term care
- Private-duty nursing
- Non-emergency care when traveling outside the U.S.
- Routine eye care (adult)
- Routine foot care
- Vision care
- Weight loss programs (except for Weight Watchers)

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture
- Bariatric surgery
- Chiropractic care (spinal manipulation)
- Hearing aids
- Infertility treatment

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-844-776-1593. You may also contact your state insurance department, by calling (503) 947-7984 or the toll free message line at (888) 877-4894; by writing to the Oregon Insurance Division, Consumer Protection Unit, 350 Winter Street NE, Salem, OR 97301-3883; through the Internet at http://www.oregon.gov/DCBS/insurance/gethelp/Pages/fileacomplaint.aspx; or by e-mail at: cp.ins@state.or.us., the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions 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 Insurance Division at 1-888-877-4894 or www.cbs.state.or.us/external/ins/consumer/html. A list of states with Consumer Assistance Programs is available at: http://www.dol.gov/ebsa/healthreform and http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

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 page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important **information about these examples.**

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,640
- **Patient pays** $1,900

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$600
Copays	$1,100
Coinsurance	$0
Limits or exclusions	$200
Total	**$1,900**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,420
- **Patient pays** $1,980

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$600
Copays	$1,100
Coinsurance	$200
Limits or exclusions	$80
Total	**$1,980**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.