




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 1-844-776-1593. 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 1-844-776-1593 to request a copy.

Important Questions	Answers	Why This Matters:
<p>What is the overall deductible?</p>	<p>For network providers \$250 individual / \$750 family; for out-of-network providers \$500 individual / \$1,500 family</p>	<p>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.</p>
<p>Are there services covered before you meet your deductible?</p>	<p>Yes. In-network preventive care, chronic condition visits, e-visits, outpatient mental health, chemical dependency and diabetes services, maternity professional services, outpatient diagnostic x-rays and labs, self-administered chemo, nutritional therapy, breastfeeding support, and the first four primary care visits, as well as in and out of network hospice care, routine nursery care, diabetic supplies, and breastfeeding supplies are covered before you meet your deductible. Copayments do not count toward your deductible.</p>	<p>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/.</p>
<p>Are there other deductibles for specific services?</p>	<p>Yes. \$50 individual / \$150 family for generic and brand prescription drugs.</p>	<p>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.</p>
<p>What is the out-of-pocket limit for this plan?</p>	<p>For network providers \$1,500 individual / \$4,500 family; for out-of-network providers \$4,000 individual / \$12,000 family; \$1,000 individual / \$3,000 family for prescription drugs. Maximum cost share: for network providers \$6,850 individual / \$13,700 family</p>	<p>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.</p>
<p>What is not included in the out-of-pocket limit?</p>	<p>Premiums, balance-billing charges, deductibles, spinal manipulation and acupuncture, emergency care, imaging, infertility, hearing exam & aids, sleep studies, additional cost tier, non-essential health benefits, and copays for out-of-network surgery.</p>	<p>Even though you pay these expenses, they don't count toward the out-of-pocket limit.</p>

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider ?	Yes. See http://www.modahealth.com/pebb or call 1-844-776-1593 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	No cost sharing for chronic condition or E-visits. \$10 copay for other primary care visits, deductible does not apply to first 4 visits	E-visits are not covered. 30% coinsurance for other visits	If a member does not select and properly use a PCP 360, claims will be paid at a lower benefit level.
	Specialist visit	\$10 copay /visit	30% coinsurance	Includes office visits by chiropractors, naturopathic physicians and acupuncturists. \$1,000 calendar year maximum for acupuncture care, spinal manipulation and massage therapy. Prior authorization is required for some spinal manipulation and acupuncture services. Failure to obtain prior authorization results in denial.
	Preventive care/screening/immunization	No charge for most services, \$10 copay /visit for remaining services. Deductible does not apply.	30% 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. A list of in-network preventive services not subject to cost sharing can be viewed at www.healthcare.gov/coverage/preventive-care-benefits/ .

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 test	Diagnostic test (x-ray, blood work)	No charge, deductible does not apply for most services; \$100 copay /visit for sleep studies.	30% coinsurance / \$100 copay /visit and 30% coinsurance for sleep studies	Includes other tests such as EKG, allergy testing and sleep study.
	Imaging (CT/PET scans, MRIs)	\$100 copay /service	\$100 copay and 30% 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.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.modahealth.com/pdl	Value drugs	No cost sharing for retail or mail-order	No cost sharing for retail prescription	Covers up to a 30-day supply (retail prescriptions); 84 to 90-day supply (participating Choice 90 pharmacies) and 90 day supply (mail-order prescription). Prior authorization may be required. Mail order at exclusive mail order pharmacy only.
	Generic drugs	\$10 copay /retail, \$25 copay /mail-order \$100 copay /specialty	\$10 copay /retail prescription	
	Brand drugs	\$30 copay /retail, \$75 copay mail-order, \$100 copay and specialty.	\$30 copay /retail prescription	Cost Sharing for self-administered chemotherapy medication is \$10 copay for a 30 day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$10 copay /visit	\$100 copay and 40% coinsurance	Prior authorization may be required. Failure to obtain prior authorization results in denial. Out-of-network bariatric surgery is not covered.
	Physician/surgeon fees	\$10 copay /visit	30% coinsurance	Prior authorization may be required. Failure to obtain prior authorization results in denial. An additional \$100 or \$500 copay is required for additional cost tier procedures.
If you need immediate medical attention	Emergency room care	\$150 copay /visit	\$150 copay /visit	In-network deductible and maximum cost share apply. Copay waived if hospital admission immediately follows. Plan coinsurance may apply to some services.
	Emergency medical transportation	\$75 copay /trip	\$75 copay /trip	None
	Urgent care	\$25 copay /visit	\$25 copay /visit	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)	\$50 copay per day / \$250 copay per admission	\$500 copay and 40% coinsurance	Prior authorization is required. Failure to obtain prior authorization results in denial. Out-of-network bariatric surgery is not covered.
	Physician/surgeon fees	\$10 copay /service	30% coinsurance	Prior authorization is required. Failure to obtain prior authorization results in denial. An additional \$100 or \$500 copay is required for additional cost tier procedures.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$10 copay /visit, deductible does not apply	40% coinsurance for non-mental health facility services, 30% coinsurance for other services	No cost sharing for substance abuse services from network providers .
	Inpatient services	\$50 copay per day / \$250 copay per admission	40% coinsurance	Prior authorization is required. Failure to obtain prior authorization results in denial. No cost sharing for substance abuse services from network providers .
If you are pregnant	Office visits	No charge, deductible does not apply.	30% coinsurance	Includes elective abortion services rendered by a licensed and certified professional provider. Cost sharing does not apply to certain preventive services . Depending on the type of services, a copayment , 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, deductible does not apply.	30% coinsurance	
	Childbirth/delivery facility services	\$50 copay per day / \$250 copay per admission	\$500 copay and 40% coinsurance	
If you need help recovering or have other special health needs	Home health care	\$10 copay /visit	30% coinsurance	Calendar year maximum of 180 visits. Prior authorization is required. Failure to obtain prior authorization results in denial.
	Rehabilitation services	\$10 copay /visit outpatient; \$50 copay per day / \$250 copay per admission for inpatient	30% coinsurance for outpatient; 40% coinsurance for inpatient	Calendar year maximum for inpatient of 30 days with an additional 30 days for head or spinal cord injury or treatment of a stroke. Calendar year maximum of 60 sessions for outpatient rehabilitation. Habilitation services are limited to services that qualify under rehabilitation guidelines and medically necessary to treat a mental health condition. Prior authorization may be required. Failure to obtain prior authorization results in denial.
	Habilitation services	\$10 copay /visit outpatient; \$50 copay per day / \$250 copay per admission for inpatient	30% coinsurance for outpatient; 40% coinsurance for inpatient	
	Skilled nursing care	\$50 copay per day / \$250 copay per admission for inpatient	40% coinsurance	Calendar year maximum of 180 days

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	Durable medical equipment	15% coinsurance	30% coinsurance	Includes supplies and prosthetics. No cost sharing for diabetic supplies or insulin. Prior authorization may be required. Failure to obtain prior authorization results in denial.
	Hospice services	No charge, deductible does not apply	No charge, deductible does not apply	None
If your child needs dental or eye care	Eye exam	No charge, deductible does not apply	Not covered	Preventive eye exam limited to in-network for children age 3-5. Eye exams are not covered for other ages.
	Glasses	Not covered	Not covered	None
	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 .)		
<ul style="list-style-type: none"> • Cosmetic Surgery, except as required for certain situations • Dental Care (Adult) except for accident related injuries 	<ul style="list-style-type: none"> • Long Term Care • Non-emergency care when traveling outside the U.S. • Private Duty Nursing 	<ul style="list-style-type: none"> • Routine eye care (Adult) • Routine Foot Care, except for diabetes • Weight Loss Programs (except for Weight Watchers)
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
<ul style="list-style-type: none"> • Acupuncture • Bariatric Surgery 	<ul style="list-style-type: none"> • Chiropractic Care • Hearing Aids 	<ul style="list-style-type: none"> • Infertility Treatment • Out-of-network preventive 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 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 1-844-776-1593. 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.

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet 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 copayment	\$10
■ Hospital (facility) copayment	\$50
■ 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	\$12,800
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$250
Copayments	\$500
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$300
The total Peg would pay is	\$1,050

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 copayment	\$10
■ Hospital (facility) copayment	\$50
■ 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	\$7,400
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$250
Copayments	\$800
Coinsurance	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Joe would pay is	\$1,310

Mia's Simple Fracture

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

■ The plan's overall deductible	\$250
■ Specialist copayment	\$10
■ Hospital (facility) copayment	\$50
■ 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	\$1,900
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$250
Copayments	\$300
Coinsurance	\$90
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$640

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 Nessler-Cass coordinates our nondiscrimination work:

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

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 مجاناً. اتصل برقم (الهاتف النصي: 711) 1-877-605-3229

بولتنے ہیں تو لسانی (URDU) توجہ دیں: اگر آپ اردو 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)

توجہ: در صورتی کہ بہ فارسی صحبت می کنید، خدمات ترجمہ بہ صورت رایگان برای شما موجود است. با تماس بگیرد. (TTY: 711) 1-877-605-3229

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 Sprachassistentendienste 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 (TTY、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。

အကူအညီ: ဤကိစ္စ (အမျိုးသားနှင့် အမျိုးမိတ်) အပေါ် စောင့်ရှောက်မှု အခမဲ့ ဖြစ်စေရန် အတွက် အကူအညီ အခမဲ့ ဖြစ်စေရန် အတွက် 1-877-605-3229 (TTY: 711) သို့ ခေါ်ဆိုပါ။

ໂປດຊາວ: 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 គឺមានផ្តល់ជូនលោកអ្នក។ 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 คุณสามารถใช้บริการช่วยเหลือด้านภาษา ได้ฟรี 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. Zadzwonić: 1-877-605-3229 (obsługa TTY: 711)