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** or by calling **1-888-217-2363**. Your policy at www.modahealth.com/members/handbooks.shtml

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-network providers: **$100** per person / **$200** per family Out-of-network providers: **$5,000** per person / **$10,000** per family. Doesn't apply to most in-network physician office visits, urgent care visit, outpatient rehabilitation, pediatric vision exam and hardware or preventive care; prescription drugs; breastfeeding support. 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?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. In-network providers **$750** per person / **$1,500** per family. Out-of-network providers **$13,700** per person / **$27,400** 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, penalties for failure to obtain prior authorization and health care this plan doesn't cover.	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 or call 1-888-217-2363** for a list of participating 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**.

- **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	$10 copay/visit	50% coinsurance	In-network **deductible** waived.
	Specialist visit	$20 copay/visit	50% coinsurance	In-network **deductible** waived.
	Other practitioner office visit	$10 copay/visit	50% coinsurance	In-network **deductible** waived. Acupuncture care, spinal manipulation and naturopathic substances are not covered.
	Preventive care/screening / immunization	No charge for most services. $10 copay/visit or 10% coinsurance for remaining services.	Not covered for most services. 50% coinsurance for some services	Only select services are covered out-of-network. Each type of service may be subject to limitations. In-network **deductible** waived for most services. A list of in-network preventive services not subject to cost sharing can be viewed at www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	50% coinsurance	Include other tests such as EKG, allergy testing and sleep study.
	Imaging (CT/PET scans, MRIs)	10% coinsurance	50% coinsurance	Prior authorization is required for many services. Failure to obtain prior authorization results 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 need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://www.modahealth.com/pdl	Value tier	$5 copay retail, $15 copay mail-order	$5 copay retail	Covers up to a 30-day supply (retail prescriptions); 90 day supply (mail-order prescription). Prior authorization may be required. Mail order at exclusive mail order pharmacy only. **Deductible** waived. Covers up to a 30-day supply specialty. Prior authorization may be required. Exclusive pharmacy only. Specialty medications may include specialty tier and other tier medications that are often used to treat complex chronic health conditions. Anticancer medication is covered at the standard coinsurance rate for in-network and out-of-network providers.
	Select tier	$5 copay retail, $15 copay mail-order	$5 copay retail	
	Preferred tier	$10 copay retail, $30 copay mail-order	$10 copay retail	
	Brand tier	25% coinsurance	25% coinsurance	
	Specialty tier	25% coinsurance	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	50% coinsurance	Prior authorization is required. Failure to obtain prior authorization results in denial.
	Physician/surgeon fees	10% coinsurance	50% coinsurance	
If you need immediate medical attention	Emergency room services	10% coinsurance	10% coinsurance	In-network **deductible** and **out-of-pocket** maximums apply.
	Emergency medical transportation	10% coinsurance	10% coinsurance	——————none——————
	Urgent care	$30 copay/visit	50% coinsurance.	In-network **deductible** waived
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	50% coinsurance	Prior authorization is required. Failure to obtain prior authorization results in denial.
	Physician/surgeon fee	10% coinsurance	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 have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$10 copay/visit	50% coinsurance	In-network **deductible** waived. For other in-network outpatient services: 10% coinsurance, deductible applies.
	Mental/Behavioral health inpatient services	10% coinsurance	50% coinsurance	Prior authorization is required for inpatient and residential services. Failure to obtain prior authorization results in denial.
	Substance use disorder outpatient services	$10 copay/visit	50% coinsurance	In-network **deductible** waived. For other in-network outpatient services: 10% coinsurance, deductible applies.
	Substance use disorder inpatient services	10% coinsurance	50% coinsurance	Prior authorization is required for inpatient and residential services. Failure to obtain prior authorization results in denial.
If you are pregnant	Prenatal and postnatal care	10% coinsurance	50% coinsurance	Includes voluntary abortion services rendered by a licensed and certified professional provider. **Deductible** waived for routine nursery care and breastfeeding support.
	Delivery and all inpatient services	10% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	50% coinsurance	Calendar year maximum of 140 visits. Prior authorization is required. Failure to obtain prior authorization results in denial.
	Rehabilitation services	$10 copay/visit for outpatient, 10% coinsurance for inpatient	50% coinsurance	Calendar year maximum of 30 days for inpatient and 30 sessions for outpatient rehabilitation and habilitation. Limits apply separately to rehabilitative and habilitative services. In-network **deductible** waived for outpatient services. Prior authorization may be required. Failure to obtain prior authorization results in denial.
	Habilitation services	$10 copay/visit for outpatient, 10% coinsurance for inpatient	50% coinsurance	
	Skilled nursing care	10% coinsurance	50% coinsurance	Calendar year maximum of 60 days.

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	Durable medical equipment	10% coinsurance; 67% coinsurance for wigs	50% coinsurance; wigs not covered	Include items such as supplies and prosthetics. Wheelchairs subject to frequency limits. Prior authorization may be required. Failure to obtain prior authorization results in denial.
	Hospice service	10% coinsurance	50% coinsurance	Hospice coverage includes respite care limits of 5 consecutive days and a lifetime maximum of 30 days.
If your child needs dental or eye care	Eye exam	No charge	50% coinsurance	In-network **deductible** waived. One exam per calendar year for members under age 19. Additional preventive eye exam limited to in-network for children age 3-5 at no cost sharing. Eye exams are not covered for other ages.
	Glasses	No charge	50% coinsurance	Covers one pair of glasses per calendar year for members under age 19. In-network **deductible** waived.
	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.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Cosmetic surgery, except as required for certain situations
- Dental care (Adult) except for accident-related injuries
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Out-of-network preventive care, with exceptions for some services
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care, with the exception for diabetes
- Weight loss programs

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.)

- Hearing aids

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your premium. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 1 888-217-2363. You may also contact your state insurance department at 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.

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, you can contact the insurer at 1-888-217-2363. 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 www.dol.gov/ebsa/healthreform and http://cciio.cms.gov/prgrams/consumer/capgrants/index.html.

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** $6,640
- **Patient pays** $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	$100
Copays	$0
Coinsurance	$600
Limits or exclusions	$200
Total	**$900**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,820
- **Patient pays** $580

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	$100
Copays	$300
Coinsurance	$100
Limits or exclusions	$80
Total	**$580**

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.

Moda Health nondiscrimination notice

Moda, Inc. complies with applicable federal civil rights laws. We do not discriminate on the basis of race, color, national origin, age, disability or sex.

Moda provides free, timely aids and services to people with disabilities to help them communicate with us effectively. These accommodations include sign language interpreters and written information in other formats.

If your primary language is not English, Moda also provides free, timely interpretation services and/or materials written in other languages.

If you need any of the services listed above, contact:

Customer Service,
888-217-2363 (TDD/TTY 711)

If you believe that Moda has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a written grievance by mailing or faxing it to:

Moda, Inc.
Attention: Appeal Unit
601 SW Second Ave.
Portland, OR 97204
Fax: 503-412-4003

If you need assistance filing a grievance, 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 to:

U.S. Department of Health
and Human Services
200 Independence Ave. SW, Room 509F
HHH Building, Washington, DC 20201

800-868-1019, 800-537-7697 (TDD).

Office for Civil Rights complaint forms are available at hhs.gov/ocr/office/file/index.html.

Moda's efforts to assure nondiscrimination are coordinated by:

Tom Bikales, VP Legal Affairs
601 SW Second Ave.
Portland, OR 97204
855-232-9111
compliance@modahealth.com

Health plans in Oregon and Alaska provided by Moda Health Plan, Inc. Dental plans in Oregon provided by Oregon Dental Service, dba Delta Dental Plan of Oregon. Dental plans in Alaska provided by Delta Dental of Alaska. 15019019 (8/16)

DELTA DENTAL
Delta Dental of Oregon & Alaska

moda HEALTH

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).

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）

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)

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)

ВНИМАНИЕ! Если Вы говорите по-русски, воспользуйтесь бесплатной языковой поддержкой. Позвоните по тел. 1-877-605-3229 (текстовый телефон: 711).

تنبيه: إذا كنت تتحدث العربية، فهناك خدمات مساعدة لغوية متاحة لك مجانًا. اتصل برقم 1-877-605-3229 (الهاتف النصي: 711)

ATANSYON: Si ou pale Kreyòl Ayisyen, nou ofri sèvis gratis pou ede w nan lang ou pale a. Rele nan 1-877-605-3229 (moun ki itilize sistèm TTY rele : 711)

ATTENTION : si vous êtes locuteurs francophones, le service d'assistance linguistique gratuit est disponible. Appelez au 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)

ATENÇÃO: Caso fale português, estão disponíveis serviços gratuitos de ajuda linguística. Telefone para 1-877-605-3229 (TERMINAL: 711)

ATTENZIONE: Se parla italiano, sono disponibili per lei servizi gratuiti di assistenza linguistica. Chiamare il numero 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。

Achtung: Falls Sie Deutsch sprechen, stehen Ihnen kostenlos Sprachassistenzdienste zur Verfügung. Rufen sie 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.

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)

โปรดทราบ: หากคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือด้านภาษาได้ฟรี โทร 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.

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