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

<table>
<thead>
<tr>
<th>What is the overall deductible?</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>For network providers $2,000 individual / $4,000 family; for out-of-network providers $6,000 individual / $12,000 family.</td>
<td>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.</td>
<td></td>
</tr>
</tbody>
</table>

| Are there services covered before you meet your deductible? | Yes. In-network primary care visits, office visits, urgent care visits, virtual care visits, outpatient rehabilitation, outpatient mental health and chemical dependency services, acupuncture, spinal manipulation, outpatient diagnostic x-rays and labs, biofeedback, tobacco cessation treatment, pediatric vision care, hearing exam, breastfeeding support, and most preventive care, as well as in and out of network prescription medications, 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? | No. | You don’t have to meet deductibles for specific services. |

| What is the out-of-pocket limit for this plan? | For network providers $7,500 individual / $15,000 family; for out-of-network providers $22,500 individual / $45,000 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, 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

<table>
<thead>
<tr>
<th>Question</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Will you pay less if you use a <a href="#">network provider</a>?</td>
<td>Yes. See <a href="http://www.modahealth.com">www.modahealth.com</a> or call 1-888-217-2363 for a list of network providers.</td>
<td>This <a href="#">plan</a> uses a provider <a href="#">network</a>. You will pay less if you use a <a href="#">provider</a> in the plan’s <a href="#">network</a>. You will pay the most if you use an <a href="#">out-of-network provider</a>, and you might receive a bill from a <a href="#">provider</a> for the difference between the provider’s charge and what your <a href="#">plan</a> pays (balance billing). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.</td>
</tr>
</tbody>
</table>

### What You Will Pay

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Network Provider (You will pay the least)</th>
<th>Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care <a href="#">provider’s</a> office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>$20 copay/visit no deductible for selected PCP.</td>
<td>$40 copay/visit no deductible for other providers.</td>
<td>$10 copay/visit, no deductible for virtual care visits</td>
</tr>
<tr>
<td><strong>Specialist visit</strong></td>
<td>$20 copay/visit no deductible for acupuncture and spinal manipulation.</td>
<td>$45 copay/visit no deductible for hearing exam.</td>
<td>$10 copay/visit, no deductible for virtual care visits</td>
<td>$40 copay/visit, no deductible for other services.</td>
</tr>
<tr>
<td>Preventive care/screening/immunization</td>
<td>No charge for most services. For remaining services: $20 copay/visit, no deductible for selected PCP, $40 copay/visit, no deductible for other providers, or 25% coinsurance.</td>
<td>Not covered for most services. 50% coinsurance for some services.</td>
<td>Not covered for most services. 50% coinsurance for some services.</td>
<td>You may have to pay for services that aren’t preventive. Ask your <a href="#">provider</a> if the services you need are preventive. Then check what your <a href="#">plan</a> will pay for. A list of in-network preventive services not subject to cost sharing can be viewed at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</td>
</tr>
</tbody>
</table>

---

All **copayment** and **coinsurance** costs shown in this chart are after your deductible has been met, if a deductible applies.
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you have a test</strong></td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>Network Provider (You will pay the least): 20% coinsurance, no deductible in outpatient/office setting</td>
<td>Out-of-Network Provider (You will pay the most): 50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>25% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td>Value tier</td>
<td>No deductible.</td>
<td>Includes other tests such as EKG, allergy testing and sleep study.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Prior authorization is required for many services. Failure to obtain prior authorization results in denial.</td>
</tr>
<tr>
<td></td>
<td>Select tier</td>
<td>$2 copay/retail prescription, $6 copay/mail-order prescription</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Preferred tier</td>
<td>No deductible.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>$40 copay/retail prescription, $120 copay/mail-order prescription</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non-Preferred tier</td>
<td>No deductible.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>40% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Specialty tier</td>
<td>No deductible</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>40% coinsurance for preferred, 50% coinsurance for non-preferred.</td>
<td></td>
</tr>
<tr>
<td><strong>If you have outpatient surgery</strong></td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>25% coinsurance</td>
<td>Prior authorization may be required. Failure to obtain prior authorization results in denial.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>25% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
</tr>
<tr>
<td>----------------------------------------------------------</td>
<td>-------------------------------------------</td>
<td>-------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>Network Provider (You will pay the least) 25% coinsurance, no deductible</td>
<td>Out-of-Network Provider (You will pay the most) 25% coinsurance, no deductible</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>25% coinsurance</td>
<td>25% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$20 copay/visit, no deductible</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$10 copay/visit, no deductible for virtual care visits</td>
<td></td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>25% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>25% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>$20 copay/office visit, no deductible 25% coinsurance for other services. $10 copay/visit, no deductible for virtual care visits</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>25% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>25% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>25% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>25% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>25% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>$40 copay/visit, no deductible outpatient. 25% coinsurance inpatient</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td>----------------------</td>
<td>----------------------</td>
<td>------------------------------------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Habilitation services</td>
<td>$40 copay/visit, no deductible outpatient. 25% coinsurance inpatient</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>25% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>25% coinsurance; 67% coinsurance for wigs</td>
<td>50% coinsurance; 67% coinsurance for wigs</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>25% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children’s eye exam</td>
<td>$20 copay/visit, no deductible</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Children’s glasses</td>
<td>25% coinsurance, no deductible</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Children’s dental check-up</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

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, except as required for certain situations
- Dental Care except for accident related injuries
- 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, 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.):

- Acupuncture
- Chiropractic Care
- Hearing Aids
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](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](http://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](http://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](http://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](http://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](http://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](http://www.HealthCare.gov).

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 a’t’ohwol ninishung, kwiijigo 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.

<table>
<thead>
<tr>
<th>Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)</th>
<th>Managing Joe’s type 2 Diabetes (a year of routine in-network care of a well-controlled condition)</th>
<th>Mia’s Simple Fracture (in-network emergency room visit and follow up care)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The plan’s overall deductible</strong> $2,000</td>
<td><strong>The plan’s overall deductible</strong> $2,000</td>
<td><strong>The plan’s overall deductible</strong> $2,000</td>
</tr>
<tr>
<td><strong>Specialist copayment</strong> $40</td>
<td><strong>Specialist copayment</strong> $40</td>
<td><strong>Specialist copayment</strong> $40</td>
</tr>
<tr>
<td><strong>Hospital (facility) coinsurance</strong> 25%</td>
<td><strong>Hospital (facility) coinsurance</strong> 25%</td>
<td><strong>Hospital (facility) coinsurance</strong> 25%</td>
</tr>
<tr>
<td><strong>Other coinsurance</strong> 25%</td>
<td><strong>Other coinsurance</strong> 25%</td>
<td><strong>Other coinsurance</strong> 25%</td>
</tr>
</tbody>
</table>

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

**In this example, Peg would pay:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Deductibles</th>
<th>Copayments</th>
<th>Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>$2,000</td>
<td>$40</td>
<td>$2,600</td>
<td></td>
</tr>
</tbody>
</table>

**What isn’t covered**
- Limits or exclusions $300
- The total Peg would pay is $4,940

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

**In this example, Joe would pay:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Deductibles</th>
<th>Copayments</th>
<th>Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>$1,700</td>
<td>$1,100</td>
<td>$30</td>
<td></td>
</tr>
</tbody>
</table>

**What isn’t covered**
- Limits or exclusions $60
- The total Joe would pay is $2,890

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

**In this example, Mia would pay:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Deductibles</th>
<th>Copayments</th>
<th>Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>$1,200</td>
<td>$500</td>
<td>$20</td>
<td></td>
</tr>
</tbody>
</table>

**What isn’t covered**
- Limits or exclusions $0
- The total Mia would pay is $1,720

The plan would be responsible for the other costs of these EXAMPLE covered services.
Moda does not discriminate

Moda, Inc. follows 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, 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 Nessel-Cass coordinates our nondiscrimination work:
Dave Nessel-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).


注意：如果您能说中文，可得到免费语言幫助服务。请致電1-877-605-3229（聲啞人專用：711）


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

FALLS SIE DEUTSCH SPRECHEN, STEHEN IHREN KOSTENLOSEN SPRACHASSISTENZDienSTEN 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、デイトレ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