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/oebb or by calling 1-866-923-0409. 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	Answers	Why This Matters:
What is the overall deductible?	For network providers $1,600 for subscriber only coverage / $3,200 for coverage with two or more enrollees; for out-of-network providers $3,200 for subscriber only coverage / $6,400 for coverage with two or more enrollees	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. In-network breastfeeding support and most preventive care, as well as in and out of network value drugs 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 $6,550 individual / $13,100 family; for out-of-network providers $13,100 individual / $26,200 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, transplants and bariatric surgery not performed at exclusive facilities, out-of-pocket expenses in excess of the reference price for an oral appliance or hip and knee replacements, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.modahealth.com/oebb or call 1-866-923-0409 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	20% coinsurance	50% coinsurance	None
	Specialist visit	20% coinsurance	50% coinsurance	Includes office visits by alternative care providers. $2,000 calendar year maximum for acupuncture care, spinal manipulation and naturopathic substances. Prior authorization is required for some chiropractic and acupuncture services. Failure to obtain prior authorization results in denial.
	Preventive care/screening/ immunization	No charge for most services. 20% coinsurance for remaining services	50% 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 https://www.healthcare.gov/coverage/preventive-care-benefits/.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	50% coinsurance	Includes other tests such as EKG, allergy testing and sleep study.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	Prior authorization is required for many services. Failure to obtain prior authorization results in denial
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	$4 copay/retail prescription, $8 copay/mail-order prescription, deductible does not apply	$4 copay/retail prescription, deductible does not apply	Covers up to a 31-day supply (retail prescriptions) and 90 day supply (mail-order prescription). Prior authorization may be required. Mail order at exclusive mail order pharmacy only. Specialty medication at exclusive specialty pharmacy only. Anticancer medication is covered at the standard coinsurance rate for in-network and out-of-network providers.
	Select and Preferred tier	20% coinsurance	20% coinsurance	
	Non-preferred tier	20% coinsurance	Not covered	

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 outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	Prior authorization may be required. Failure to obtain prior authorization results in denial. Adult member only benefit of gastric bypass has an additional $500 copay.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	None
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	20% coinsurance	50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	Prior authorization is required. Failure to obtain prior authorization results in denial.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	50% coinsurance	None
	Inpatient services	20% coinsurance	50% coinsurance	Prior authorization is required. Failure to obtain prior authorization results in denial.
If you are pregnant	Office visits	20% coinsurance	50% coinsurance	Includes voluntary 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	20% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	

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	Home health care	20% coinsurance	50% coinsurance	Calendar year maximum of 140 visits for out-of-network providers. Prior authorization may be required. Failure to obtain prior authorization results in denial.
	Rehabilitation services	20% coinsurance	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. Prior authorization may be required. Failure to obtain prior authorization results in denial.
	Habilitation services	20% coinsurance	50% coinsurance	
	Skilled nursing care	20% coinsurance	50% coinsurance	Calendar year maximum of 60 visits
	Durable medical equipment	20% coinsurance	50% coinsurance	Includes 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 services	20% coinsurance	50% coinsurance	None
If your child needs dental or eye care	Eye exam	No charge	50% coinsurance	Preventive eye screening for children age 3-5 at no cost sharing. 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.)

- Cosmetic Surgery, except as required for certain situations
- Dental Care (Adult) except for accident related injuries
- Infertility Treatment
- Long Term Care
- Private Duty Nursing
- Routine eye care (Adult)
- Routine Foot Care, with exception 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.)

- Acupuncture
- Bariatric Surgery (for members who meet specific medical criteria)
- Chiropractic Care
- Hearing Aids
- Non-emergency care when traveling outside the U.S.

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 1-888-217-2363. 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 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, 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.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$1,600
Specialist copayment	$0
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	$12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,600
Copayments	$0
Coinsurance	$2,200
What isn't covered	
Limits or exclusions	$300
The total Peg would pay is	$4,100

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

The plan's overall deductible	$1,600
Specialist copayment	$0
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	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,600
Copayments	$0
Coinsurance	$1,100
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	$2,760

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

The plan's overall deductible	$1,600
Specialist copayment	$0
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	$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,600
Copayments	$0
Coinsurance	$70
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,670

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact your group administrator.

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

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

800-368-1019, 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（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。

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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