



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 1-877-337-0649. 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 1-877-337-0649 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	For network providers \$250 individual / \$750 family in a plan year; for out-of-network providers \$650 individual / \$1,950 family in a plan year	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. Examples of some services: In-network office visits for primary care, specialists and urgent care, preventive care , outpatient diagnostic tests, alternative care and prescription medications, as well as in and out of network emergency room care, 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 \$1,800 individual / \$5,400 family in a plan year; for out-of-network providers \$10,500 individual / \$31,500 family in a plan year	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, certain specialty pharmacy drugs that are considered non-essential health benefits, 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 or call 1-877-337-0649 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 charge No charge/CirrusMD virtual visit	40% coinsurance	None.
	Specialist visit	No charge No charge/CirrusMD virtual visit	40% coinsurance	Includes office visits by chiropractors and acupuncturists. Up to 28 visits per plan year for spinal manipulation.
	Preventive care / screening / immunization	No charge.	40% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	40% coinsurance	Includes other tests such as EKG, allergy testing and sleep study.
	Imaging (CT/PET scans, MRIs)	No charge	40% coinsurance	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 need drugs to treat your illness or condition Prescriptions are covered under the CityCore Express Scripts Prescription Plan. More information about prescription drug coverage is available at www.express-scripts.com 855-889-7760	Generic medications	No charge	40% coinsurance (benefits through the medical plan)	Covers up to a 30-day supply (retail prescriptions); or up to a 90 day supply of maintenance medications at maintenance retail pharmacies. Specialty medications must be filled through Accredo Specialty Pharmacy.
	Preferred brand medications	No charge	40% coinsurance (benefits through the medical plan)	Preauthorization may be required. Member to pay difference in cost for brand-name drugs with generic alternative.
	Non-preferred brand medications	No charge	40% coinsurance (benefits through the medical plan)	Brand/generic penalty applies if brand drugs are requested when generic is available for a multi-source brand name drug. \$35 maximum cost share 30-day supply and \$105 maximum cost share 90-day supply for insulin, deductible does not apply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	40% coinsurance	Preauthorization may be required. Failure to get preauthorization results in a delay of benefits.
	Physician/surgeon fees	No charge	40% coinsurance	
If you need immediate medical attention	Emergency room care	\$200 copay /visit, then 20% coinsurance , deductible does not apply	\$200 copay /visit, then 20% coinsurance , deductible does not apply	Copay waived if hospital admission immediately follows. Plan deductible and coinsurance may apply to some services. In-network out-of-pocket limit applies.
	Emergency medical transportation	20% coinsurance , deductible does not apply	20% coinsurance , deductible does not apply	In-network out-of-pocket limit apply.
If you need immediate medical attention	Urgent care	No charge No charge/CirrusMD virtual visit	40% coinsurance , deductible does not apply	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)	20% coinsurance	40% coinsurance	Preauthorization is required. Failure to get preauthorization results in a delay of benefits.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge No charge/CirrusMD virtual visit	40% coinsurance	Preauthorization is required for some services. Failure to obtain preauthorization results in a delay of benefits.
	Inpatient services	No charge.	40% coinsurance	Preauthorization is required. Failure to obtain preauthorization results in a delay of benefits.
If you are pregnant	Office visits	\$250 copay (includes professional services), deductible does not apply	40% coinsurance	Cost sharing does not apply for preventive services . Depending on the type of services, a copay , coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	\$250 copay (includes office visits), deductible does not apply	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	No charge	40% coinsurance	Plan year maximum of 60 visits. Preauthorization may be required. Failure to obtain preauthorization results in a delay of benefits.
	Rehabilitation services	No charge	40% coinsurance	Therapy is expected to result in continued improvement of the person's condition.
	Habilitation services	No charge	40% coinsurance	
	Skilled nursing care	20% coinsurance	40% coinsurance	Plan year maximum of 30 days
	Durable medical equipment	No charge	40% coinsurance	Includes supplies and prosthetics. Preauthorization may be required. Failure to obtain preauthorization results in a delay of benefits.
	Hospice services	No charge	40% coinsurance	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 your child needs dental or eye care	Children's eye exam	Covered under preventive	Not covered	Limited to in-network preventive vision screening for children age 3-5. Other vision services available through VSP (800-877-7195 or www.vsp.com)
	Children's glasses	Not covered	Not covered	
	Children's 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 - Naturopathic supplies	- Private Duty Nursing - Routine Foot Care, except for diabetes

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
- Abortion - Acupuncture - Bariatric Surgery	- Chiropractic Care - Hearing Aids - Non-emergency care when traveling outside the U.S.	- Routine eye care (Adult) - Weight Loss Programs

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 1-877-337-0649. 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.

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

Does this plan meet the 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	\$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	\$12,700
---------------------------	-----------------

In this example, Peg would pay:

Cost Sharing	
Deductibles	\$250
Copayments	\$0
Coinsurance	\$1,550

What isn't covered	
Limits or exclusions	\$50
The total Peg would pay is	\$1,850

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	\$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	\$5,600
---------------------------	----------------

In this example, Joe would pay:

Cost Sharing	
Deductibles	\$200
Copayments	\$0
Coinsurance	\$40

What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$260

Mia's Simple Fracture

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

■ The plan's overall deductible	\$250
■ 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	\$2,800
---------------------------	----------------

In this example, Mia would pay:

Cost Sharing	
Deductibles	\$250
Copayments	\$200
Coinsurance	\$200

What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$650

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.