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 1-888-445-7413. 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 1-888-445-7413 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$200 individual / $600 family in a calendar 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. In-network hospice care and diabetes self-management program as well as in and out-of-network tobacco cessation treatment, prescription drugs, spinal manipulation, naturopathic supplies, massage therapy, vision care, breastfeeding supplies and most preventive 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 medical services, $1,250 individual / $3,750 family in a calendar year, in-network and out-of-network combined; for prescription medications $2,000 individual / $6,000 family in a calendar year, in-network and out-of-network combined	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, coinsurance for hearing aids for age 26 and older, coinsurance for brand medications when generic medications are available, penalties for failure to obtain prior authorization, 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	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See www.modahealth.com or call 1-888-445-7413 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	10% coinsurance	30% coinsurance	None
	Specialist visit	10% coinsurance and 50% coinsurance and deductible does not apply to spinal manipulation, naturopathic supplies and massage therapy	30% coinsurance and 50% coinsurance and deductible does not apply to spinal manipulation, naturopathic supplies and massage therapy	Office visits by chiropractors, naturopathic physicians and acupuncturists do not have a dollar or visit limit. $300 plan year maximum for spinal manipulation, naturopathic supplies and massage therapy. $300 limit does not apply to the insertion of needles for acupuncture care. 20 visits plan year maximum for acupuncture care.
	Preventive care/screening/ immunization	No charge for most services. 10% coinsurance for remaining services and deductible does not apply.	30% coinsurance and deductible does not apply to most services.	Includes preventive tests. 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)	10% coinsurance	30% coinsurance	Includes other tests such as EKG, allergy testing and sleep study.
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	Prior authorization is required for many services. Failure to obtain prior authorization results in denial. In-network providers will write off the charges due to no prior authorization.

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 More information about prescription drug coverage is available at www.welldynerx.com	Tier 1 Select	Deductible does not apply. 20% coinsurance	Deductible does not apply. 20% coinsurance	Prescription drug benefits are administered by WellDyne Rx. Prior authorization may be required. Retail - Up to a 30-day supply and Tier 1 and Tier 2 have a $50 maximum per prescription. Mail order - 90-day supply; Tier 1 has a $25 maximum and Tier 2 has a $100 maximum per prescription. Mail-order prescriptions required to be filled in-network. Prescriptions purchased at an out-of-network pharmacy may be subject to "balance billing." You are responsible to pay the difference in cost between brand and generic drug when generic is available. Specialty – Up to a 30-day supply and Tier 1 and Tier 2 have a $50 maximum per prescription. Exclusive pharmacy only.
	Tier 2 Preferred	Deductible does not apply. 20% coinsurance	Deductible does not apply. 20% coinsurance	
	Tier 3 Non-Formulary	Deductible does not apply. 50% coinsurance	Deductible does not apply. 50% coinsurance	
	Specialty Medications	Deductible does not apply. 20% coinsurance Tier 1 and 2; 50% coinsurance Tier 3	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance	Prior authorization may be required. Failure to obtain prior authorization results in a penalty and the procedure is not covered if not medically necessary. In-network sterilization procedures are covered with no cost sharing.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	
If you need immediate medical attention	Emergency room care	$50 copay/visit, then 10% coinsurance	$50 copay/visit, then 10% coinsurance	Copay waived if hospital admission immediately follows. Plan coinsurance may apply to some services.
	Emergency medical transportation	10% coinsurance	10% coinsurance	Transport to nearest facility capable to provide necessary treatment.
	Urgent care	10% coinsurance	30% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	Prior authorization is required. Failure to obtain prior authorization results in a penalty and the procedure is not covered if not medically necessary.
	Physician/surgeon fees	10% coinsurance	30% 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 mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance	30% coinsurance	Prior authorization required for all inpatient and some outpatient behavioral health services. Failure to obtain prior authorization results in a penalty and the procedure is not covered if not medically necessary.
	Inpatient services	10% coinsurance	30% coinsurance	
If you are pregnant	Office visits	10% coinsurance	30% coinsurance	In-network elective abortion is covered at no cost sharing. 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	10% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	30% coinsurance	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	30% coinsurance	Plan year maximum of 60 visits. Prior authorization is required. Failure to obtain prior authorization results in a penalty and the procedure is not covered if not medically necessary.
	Rehabilitation services	10% coinsurance	30% coinsurance	Plan 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 is required. Failure to obtain prior authorization results in a penalty and the procedure is not covered if not medically necessary. I
	Habilitation services	10% coinsurance	30% coinsurance	
	Skilled nursing care	10% coinsurance	30% coinsurance	Plan year maximum of 100 visits. Prior authorization is required. Failure to obtain prior authorization results in a penalty and the procedure is not covered if not medically necessary.
	Durable medical equipment	10% coinsurance	30% coinsurance	Includes supplies and prosthetics. Prior authorization may be required. Failure to obtain prior authorization results in a penalty and the procedure is not covered if not medically necessary.
	Hospice services	No charge, deductible does not apply	30% coinsurance	Plan year maximum of 120 hours for respite care in a 3 month period.

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	Eye exam	No charge, deductible does not apply	No charge, deductible does not apply	Preventive eye exam limited to in-network for children age 3-5. All other vision benefits are administered by Vision Service Plan (VSP).
	Glasses	No charge, deductible does not apply	No charge, deductible does not apply	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.)

- Bariatric Surgery
- 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.
- Private Duty Nursing
- 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
- Routine eye 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 1-888-445-7143. 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	$200
Specialist copayment	10%
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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

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

The plan's overall deductible	$200
Specialist copayment	10%
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	$200
Copayments	$0
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	$1,260

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

The plan's overall deductible	$200
Specialist copayment	10%
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	$200
Copayments	$50
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$450

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

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 Nesseler-Cass coordinates our nondiscrimination work:

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

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. Health plans provided by Moda Health Plan, Inc. Individual medical plans in Alaska provided by Moda Assurance Company. 39969758 (9/19)

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DELTA DENTAL
Delta Dental of Oregon & Alaska

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

توجہ دیں: اگر آپ اردو (URDU) بولتے ہیں تو لسانی اعانت آپ کے لیے بلا معاوضہ دستیاب ہے۔ 1-877-605-3229 (TTY: 711) پر کال کریں

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)

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.

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 Sprachassistenzdienste 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（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。

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અગત્યનું: જો તમે (ભાષાંતર કરેલ ભાષા અહીં દર્શાવો) બોલો છો તો તે ભાષામાં તમારે માટે વિના મૂલ્યે સહાય ઉપલબ્ધ છે. 1-877-605-3229 (TTY: 711) પર કૉલ કરો

ໂປດຊາບ: 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 คุณสามารถใช้บริการช่วยเหลือด้านภาษาได้ฟรี 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. Zadzwoń: 1-877-605-3229 (obsługa TTY: 711)

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DELTA DENTAL

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