Moda Health Plan, Inc.: OEBB – Statewide – Birch

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 10/01/2016 – 09/30/2017
Coverage for: Individual + Family | **Plan Type:** PPO

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/oebb** or by calling **1-866-923-0409**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-network providers: **$800** per person / **$2,400** per family. Out-of-network providers: **$1,600** per person / **$4,800** per family. Doesn't apply to most in-network preventive care, incentive care, substance abuse or mental health office visits. Urgent care visit, routine nursery care, prescription drugs, or 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: **$4,000** per person / **$12,000** per family. Out-of-network providers: **$8,000** per person / **$24,000** per family. Maximum cost share: In-network providers **$6,850** per person / **$13,700** 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, 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**.
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/oebb or call 1-866-923-0409** 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**.

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- **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	20% coinsurance	50% coinsurance	$15 copay for in-network Moda Medical Home incentive care visits, **deductible** waived. $30 copay for in-network Moda Medical Home primary care visits, **deductible** waived
	Specialist visit	20% coinsurance	50% coinsurance	Includes office visits by alternative care providers.
	Other practitioner office visit	20% coinsurance	50% coinsurance	$2,000 plan year maximum for acupuncture care, spinal manipulation and naturopathic substances. Not applicable to office visits by other practitioners.
	Preventive care/screening / immunization	No charge	50% coinsurance	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)	20% coinsurance	50% coinsurance	Include other tests such as EKG, allergy testing and sleep study. Some services require a $100 copay.
	Imaging (CT/PET scans, MRIs)	$100 copay, then 20% coinsurance	$100 copay, then 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 www.modahealth.com/oebb and choose "Group Plan" then "Pharmacy"	Value tier	$4 copay retail, $8 copay mail-order	$4 copay retail	Covers up to a 31-day supply (retail and specialty prescriptions); 90 day supply (mail-order prescription). Value and Select tiers (retail) up to a 90-day supply for three times copay. Prior authorization may be required. Mail order at exclusive mail order pharmacy only. Specialty medication at exclusive specialty pharmacy only. **Deductible** waived. Prescription copays and coinsurance apply to the maximum cost share. Anticancer medication is covered at no charge for in-network providers.
	Select tier	$12 copay retail, $24 copay mail-order	$12 copay retail	
	Preferred tier	25% coinsurance, up to $75 maximum retail; 25% coinsurance, up to $150 maximum mail-order and up to $200 maximum specialty	25% coinsurance, up to $75 maximum retail	
	Non-Preferred tier	50% coinsurance, up to $175 maximum retail; 50% coinsurance, up to $450 maximum mail-order and up to $500 maximum specialty	50% coinsurance, up to $175 maximum retail	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	Prior authorization may be required to avoid a penalty of 50% up to a maximum deduction of $2,500.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	
If you need immediate medical attention	Emergency room services	$100 copay/visit, then 20% coinsurance	$100 copay/visit, then 20% coinsurance	Copay waived if hospital admission immediately follows. **Deductible** waived.
	Emergency medical transportation	20% coinsurance	20% coinsurance	——————none——————.
	Urgent care	$50 copay/visit	$50 copay/visit	**Deductible** waived.

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If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	Prior authorization is required to avoid a penalty of 50% up to a maximum deduction of $2,500. Additional copay for certain outpatient and hospital services.
	Physician/surgeon fee	20% coinsurance	50% coinsurance	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$30 copay/visit	50% coinsurance	In-network **deductible** waived. For other in-network outpatient services: 20% coinsurance
	Mental/Behavioral health inpatient services	20% coinsurance	50% coinsurance	Prior authorization is required for inpatient and residential services to avoid a penalty of 50% up to a maximum deduction of $2,500.
	Substance use disorder outpatient services	No charge	50% coinsurance	In-network **deductible** waived. For other in-network outpatient services: 20% coinsurance
	Substance use disorder inpatient services	No charge	50% coinsurance	Prior authorization is required for inpatient and residential services to avoid a penalty of 50% up to a maximum deduction of $2,500.
If you are pregnant	Prenatal and postnatal care	20% 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	20% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	Plan year maximum of 140 visits. Prior authorization required to avoid a penalty of 50% up to a maximum deduction of $2,500.
	Rehabilitation services	20% coinsurance	50% coinsurance	Plan year maximum of 30 days for inpatient and 30 sessions for outpatient rehabilitation. Habilitation services are limited to services that qualify under rehabilitation guidelines and medically necessary to treat a mental health condition..
	Habilitation services	20% coinsurance	50% coinsurance	
	Skilled nursing facility care	20% coinsurance	50% coinsurance	Plan year maximum of 60 days.

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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 (continued)	Durable medical equipment	20% coinsurance	50% coinsurance	Include items such as supplies and prosthetics. Wheelchairs subject to frequency limits. Prior authorization may be required to avoid a penalty of 50% up to a maximum deduction of $2,500.
	Hospice service	20% coinsurance	50% coinsurance	——————none——————
If your child needs dental or eye care	Eye exam	Covered under preventive	50% coinsurance	In-network **deductible** waived. Preventive eye exam limited to children age 3-5.
	Glasses	Not covered	Not covered	——————none——————
	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.)

- 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 the exception for diabetes
- Weight loss programs (except for Weight Watchers)

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.)

- Acupuncture
- Bariatric surgery (for subscribers who meet specific medical criteria)
- Chiropractic care
- Hearing aids
- Non-emergency care when traveling outside the U.S.

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Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-866-923-0409. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov

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 1-866-923-0409. 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.**

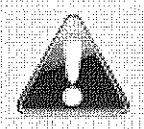
Language Access Services:

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** $5,220
- **Patient pays** $2,320

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	$800
Copays	$20
Coinsurance	$1,300
Limits or exclusions	$200
Total	**$2,320**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,620
- **Patient pays** $1,780

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	$800
Copays	$800
Coinsurance	$100
Limits or exclusions	$80
Total	**$1,680**

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.