



	Gold plans		Silver plans		Bronze plans	
	Moda Select Gold 1000 Separate Rx + Vision Exam	Moda Select Gold 2200 + Vision Exam	Moda Select Silver 3000 Separate Rx + Vision Exam	Moda Select Silver 6400 + Vision Exam	Moda Select Bronze 8900 + Vision Exam	Moda Select Bronze HSA 7500
What you pay for the <i>in-network</i> care you receive each year						
Deductible per person	\$1,000	\$2,200	\$3,000	\$6,400	\$8,900	\$7,500
Deductible per family	\$2,000	\$4,400	\$6,000	\$12,800	\$17,800	\$15,000
Pharmacy deductible per person	\$500	N/A	\$1,500	N/A	N/A	N/A
Pharmacy deductible per family	\$1,000	N/A	\$3,000	N/A	N/A	N/A
Out-of-pocket max per person	\$8,000	\$7,600	\$8,250	\$7,350	\$9,450	\$7,500
Out-of-pocket max per family	\$16,000	\$15,200	\$16,500	\$14,700	\$18,900	\$15,000
Out-of-network benefits available*	✓	✓	✓	✓	✓	✓
Benefits that make up your plan and what you pay						
Primary care provider (PCP) office visit	\$15 per visit	\$10 per visit	\$25 per visit	\$25 per visit	\$50 per visit	0% after deductible
Specialist office visit	\$30 per visit	\$30 per visit	\$70 per visit	\$70 per visit	\$90 per visit	0% after deductible
Urgent care visit	\$30 per visit	\$30 per visit	\$70 per visit	\$70 per visit	\$90 per visit	0% after deductible
Virtual care visit	\$5 per visit	\$0 per visit	\$15 per visit	\$15 per visit	\$40 per visit	0% after deductible
Emergency room visit	15% after deductible	10% after deductible	35% after deductible	35% after deductible	10% after deductible	0% after deductible
Spinal manipulation	\$30 per visit	\$30 per visit	\$70 per visit	\$70 per visit	\$90 per visit	0% after deductible
Mental health and substance use disorder office visit	\$15 per visit	\$10 per visit	\$25 per visit	\$25 per visit	\$50 per visit	0% after deductible
Outpatient rehabilitation	\$30 per visit	\$30 per visit	\$70 per visit	\$70 per visit	10% after deductible	0% after deductible
Inpatient/outpatient care	15% after deductible	10% after deductible	35% after deductible	35% after deductible	10% after deductible	0% after deductible
Pharmacy benefits¹						
Value	\$2	\$2	\$2	\$2	\$2	0%
Select	\$10	\$5	\$20	\$20	\$20	0% after deductible
Preferred	30% after deductible	30%	40% after deductible	40%	40%	0% after deductible
Non-preferred	50% after deductible	50%	50% after deductible	50% after deductible	50% after deductible	0% after deductible
Preferred specialty	30% after deductible	30%	40% after deductible	40%	40%	0% after deductible
Non-preferred specialty	50% after deductible	50%	50% after deductible	50% after deductible	50% after deductible	0% after deductible
Things to consider when choosing your plan						
Features and special benefits included in your plan	PCP +	PCP +	PCP +	PCP +	PCP +	HSA PCP +

¹ One copay for a 30-day supply

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Plan highlights

- Out-of-network benefits available**
For out-of-network benefits, scan the QR code, then click the Summary of Benefits (SOB) link for detailed information on each plan.
 
- Choose a PCP**
To help you manage your health, we highly encourage selecting an in-network PCP.
- Health savings account**
Our health savings account (HSA)-compatible, high-deductible health plan (Bronze HSA 7500) gives you flexibility and choice. You have the freedom to choose any financial institution for your HSA. You can use HSA tax-free dollars to pay for deductibles, coinsurance and other qualified expenses not covered by your health plan.
- Included with all plans**
 - Unlimited mental health and substance disorder in person office visits
 - Rehabilitation and habilitation benefits (physical, occupational and speech therapy) limited to separate 20 sessions per year
 - Spinal manipulation limited to 18 visits per year

Health partners in your area

Not all providers at these locations are in-network.



Southeast Idaho





Save more

In addition to a tax credit, members may be eligible for a **cost-sharing reduction plan** that lowers the amount paid out-of-pocket for deductibles, coinsurance, and copays. Members of federally recognized American Indian and Alaska Native tribes may also qualify for additional cost-sharing benefits.



2024

Cost-sharing reduction (CSR) plans

	Moda Select Silver 3000			Moda Select Silver 6400		
	CSV1 73% CSR	CSV2 87% CSR	CSV3 94% CSR	CSV1 73% CSR	CSV2 87% CSR	CSV3 94% CSR

What you pay for the *in-network* care you receive each year

Deductible per person	\$2,750	\$750	\$100	\$2,500	\$750	\$100
Deductible per family	\$5,500	\$1,500	\$200	\$5,000	\$1,500	\$200
Pharmacy deductible per person	\$1,250	\$375	\$50	N/A	N/A	N/A
Pharmacy deductible per family	\$2,500	\$750	\$100	N/A	N/A	N/A
Out-of-pocket max per person	\$6,750	\$2,000	\$750	\$6,350	\$2,000	\$750
Out-of-pocket max per family	\$13,500	\$4,000	\$1,500	\$12,700	\$4,000	\$1,500
Out-of-network benefits available	✓	✓	✓	✓	✓	✓

Benefits that make up your plan and what you pay

Primary care provider (PCP) office visit	\$25 per visit	\$20 per visit	\$10 per visit	\$25 per visit	\$20 per visit	\$10 per visit
Specialist office visit	\$70 per visit	\$40 per visit	\$20 per visit	\$70 per visit	\$40 per visit	\$20 per visit
Urgent care visit	\$70 per visit	\$40 per visit	\$20 per visit	\$70 per visit	\$40 per visit	\$20 per visit
Virtual care visit	\$15 per visit	\$10 per visit	\$5 per visit	\$15 per visit	\$10 per visit	\$5 per visit
Emergency room visit	35% after deductible					
Spinal manipulation	\$70 per visit	\$40 per visit	\$20 per visit	\$70 per visit	\$40 per visit	\$20 per visit
Mental health and substance use disorder office visit	\$25 per visit	\$20 per visit	\$10 per visit	\$25 per visit	\$20 per visit	\$10 per visit
Outpatient rehabilitation	\$70 per visit	\$40 per visit	\$20 per visit	\$70 per visit	\$40 per visit	\$20 per visit
Inpatient/outpatient care	35% after deductible					

Pharmacy benefits¹

Value	\$2	\$2	\$2	\$2	\$2	\$2
Select	\$20	\$20	\$10	\$20	\$20	\$10
Preferred	40% after deductible	40% after deductible	40% after deductible	40%	40%	40%
Non-preferred	50% after deductible					
Preferred specialty	40% after deductible	40% after deductible	40% after deductible	40%	40%	40%
Non-preferred specialty	50% after deductible					

Things to consider when choosing your plan

Features and special benefits included in your plan	PCP +					
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Limitations

- Authorization by Moda Health is required for all medical and surgical admissions and some outpatient services and medications
- Biofeedback is limited to 10 visits per lifetime for tension or migraine headaches
- Brand tier medications – if members use a brand medication when a generic equivalent is available, they will have to pay the non-preferred cost sharing plus the difference in cost between the generic and brand medication
- Coordination of Benefits – when a member has more than one health plan, combined benefits for all plans is limited to the maximum plan allowance for all covered services
- Hearing aids are covered once every 36 months for children with certain medical conditions
- Hospital stay and inpatient rehabilitation benefits are limited to \$2,000 per day for out-of-network non-emergency admission
- Infusion therapy – some medications require use of an authorized provider to be eligible for coverage. Outpatient hospital setting is not covered for some medications.
- Prescriptions are limited to a maximum 30-day supply per prescription for most specialty pharmacy and up to a 90-day supply per prescription for retail and mail order pharmacies
- Preventive care – cost sharing may apply to services not required under the Affordable Care Act
- Rehabilitation and habilitation benefits include separate limits of 20 outpatient sessions per year
- Skilled nursing facility is limited to 30 days per year
- Spinal manipulation is limited to 18 visits per year
- Vision exam and glasses or contacts are covered once per year for members under age 19
- Adult vision exam once per year

Exclusions

- Abortion, except the mother's life is at risk or the pregnancy is a result of rape or incest
- Acupuncture
- Care outside the United States, other than urgent or emergency care
- Charges above the maximum plan allowance
- Cosmetic services and supplies (exception for reconstructive surgery if medically necessary and not specifically excluded)
- Court-ordered sex offender treatment
- Custodial care
- Dental examinations and treatment (except for accidental injury)
- Experimental or investigational treatment
- Faith healing
- Infertility (services or supplies for treatment of, including reversal of sterilization)
- Injury resulting from practicing for or participating in professional athletic events
- Instruction programs, except as provided under the outpatient diabetic instruction benefit
- Massage or massage therapy
- Naturopathic supplies, including herbal, homeopathic medicines, substances or devices and any other nonprescription supplements
- Obesity (all services and supplies except those required under the Affordable Care Act)
- Optional services or supplies, including those for comfort, convenience, environmental control or education, and treatment not medically necessary
- Orthognathic surgery, except when medically necessary to repair an accidental injury or for treatment of cancer
- Services or supplies available under any city, county, state or federal law, except Medicaid
- Services ordered or provided by the patient or a member of the patient's immediate family
- Temporomandibular Joint Syndrome (TMJ)
- Vision surgery to alter the refractive character of the eye

¹ One copay for a 30-day supply

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