



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](http://www.modahealth.com) or by calling 1-844-931-1775. 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](http://www.healthcare.gov/sbc-glossary) or call 1-844-931-1775 to request a copy.

| Important Questions                                                             | Answers                                                                                                                                                                                                                                                                                                 | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|---------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall <a href="#">deductible</a> ?                                | \$0                                                                                                                                                                                                                                                                                                     | See the Common Medical Events chart below for your costs for services this <a href="#">plan</a> covers.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | Yes. All services are covered before you meet your <a href="#">deductible</a> .                                                                                                                                                                                                                         | This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .                                                                       |
| Are there other <a href="#">deductibles</a> for specific services?              | No.                                                                                                                                                                                                                                                                                                     | You don't have to meet <a href="#">deductibles</a> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | Not applicable.                                                                                                                                                                                                                                                                                         | This <a href="#">plan</a> does not have an <a href="#">out-of-pocket limit</a> on your expenses.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| What is not included in the <a href="#">out-of-pocket limit</a> ?               | Not applicable                                                                                                                                                                                                                                                                                          | This <a href="#">plan</a> does not have an <a href="#">out-of-pocket limit</a> on your expenses.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| Will you pay less if you use a <a href="#">network provider</a> ?               | Yes. See <a href="https://www.modahealth.com/ProviderSearch?productCategory=medical&amp;selectedNetwork=Moda%20Select">https://www.modahealth.com/ProviderSearch?productCategory=medical&amp;selectedNetwork=Moda%20Select</a> or call 1-844-931-1775 for a list of <a href="#">network providers</a> . | This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services. |
| Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?    | No.                                                                                                                                                                                                                                                                                                     | You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |



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                                                                                                                                                                                                                                                  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|-------------------------------------------------------------|--------------------------------------------------|----------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                                              |                                                        | Indian Health Care Provider (IHCP) (You will pay the least) | Non-IHCP In-Network Provider (You will pay more) | Non-IHCP Out-of-Network Provider (You will pay the most) |                                                                                                                                                                                                                                                                                                         |
| <b>If you visit a health care <a href="#">provider's</a> office or clinic</b>                                                                                                                                                | Primary care visit to treat an injury or illness       | No charge                                                   | No charge                                        | No charge                                                | None                                                                                                                                                                                                                                                                                                    |
|                                                                                                                                                                                                                              | <a href="#">Specialist</a> visit                       | No charge                                                   | No charge                                        | No charge                                                | Office visits by naturopaths and chiropractors are specialist visits.                                                                                                                                                                                                                                   |
|                                                                                                                                                                                                                              | <a href="#">Preventive care/screening/immunization</a> | No charge                                                   | No charge                                        | No charge                                                | You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.                                                                                                               |
| <b>If you have a test</b>                                                                                                                                                                                                    | <a href="#">Diagnostic test</a> (x-ray, blood work)    | No charge                                                   | No charge                                        | No charge                                                | Includes other tests such as EKG, allergy testing and sleep study. <a href="#">Preauthorization</a> may be required to avoid a penalty of 50% up to a maximum deduction of \$2,500.                                                                                                                     |
|                                                                                                                                                                                                                              | Imaging (CT/PET scans, MRIs)                           | No charge                                                   | No charge                                        | No charge                                                | <a href="#">Preauthorization</a> may be required to avoid a penalty of 50% up to a maximum deduction of \$2,500.                                                                                                                                                                                        |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <a href="#">prescription drug coverage</a> is available at <a href="https://www.modahealth.com/pdl">https://www.modahealth.com/pdl</a> | Value tier                                             | No charge                                                   | No charge                                        | No charge                                                | <a href="#">Preauthorization</a> may be required.                                                                                                                                                                                                                                                       |
|                                                                                                                                                                                                                              | Select tier                                            | No charge                                                   | No charge                                        | No charge                                                | Covers up to a 30-day supply (retail pharmacy) and 90-day supply (mail order and participating retail pharmacies). <a href="#">Preauthorization</a> may be required. Mail order at a Moda Health designated mail order pharmacy or pharmacies that agree to follow our terms for mail order pharmacies. |
|                                                                                                                                                                                                                              | Preferred tier                                         | No charge                                                   | No charge                                        | No charge                                                |                                                                                                                                                                                                                                                                                                         |
|                                                                                                                                                                                                                              | Non-preferred tier                                     | No charge                                                   | No charge                                        | No charge                                                |                                                                                                                                                                                                                                                                                                         |
|                                                                                                                                                                                                                              | <a href="#">Specialty drug</a> tier                    | No charge                                                   | No charge                                        | No charge                                                | Covers up to a 30-day supply for most specialty.<br><a href="#">Cost sharing</a> for anticancer medication is 0%.                                                                                                                                                                                       |

| Common Medical Event                                                      | Services You May Need                            | What You Will Pay                                           |                                                  |                                                          | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                   |
|---------------------------------------------------------------------------|--------------------------------------------------|-------------------------------------------------------------|--------------------------------------------------|----------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                           |                                                  | Indian Health Care Provider (IHCP) (You will pay the least) | Non-IHCP In-Network Provider (You will pay more) | Non-IHCP Out-of-Network Provider (You will pay the most) |                                                                                                                                                                                                                                                                                                                          |
| If you have outpatient surgery                                            | Facility fee (e.g., ambulatory surgery center)   | No charge                                                   | No charge                                        | No charge                                                | <a href="#">Preauthorization</a> may be required to avoid a penalty of 50% up to a maximum deduction of \$2,500.                                                                                                                                                                                                         |
|                                                                           | Physician/surgeon fees                           | No charge                                                   | No charge                                        | No charge                                                |                                                                                                                                                                                                                                                                                                                          |
| If you need immediate medical attention                                   | <a href="#">Emergency room care</a>              | No charge                                                   | No charge                                        | No charge                                                | None                                                                                                                                                                                                                                                                                                                     |
|                                                                           | <a href="#">Emergency medical transportation</a> | No charge                                                   | No charge                                        | No charge                                                | None                                                                                                                                                                                                                                                                                                                     |
|                                                                           | <a href="#">Urgent care</a>                      | No charge                                                   | No charge                                        | No charge                                                | None                                                                                                                                                                                                                                                                                                                     |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)               | No charge                                                   | No charge                                        | No charge                                                | The plan allows up to \$2,000 per day for out-of-network non-emergency admission. <a href="#">Preauthorization</a> may be required to avoid a penalty of 50% up to a maximum deduction of \$2,500.                                                                                                                       |
|                                                                           | Physician/surgeon fees                           | No charge                                                   | No charge                                        | No charge                                                |                                                                                                                                                                                                                                                                                                                          |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                              | No charge                                                   | No charge                                        | No charge                                                | <a href="#">Preauthorization</a> may be required to avoid a penalty of 50% up to a maximum deduction of \$2,500.                                                                                                                                                                                                         |
|                                                                           | Inpatient services                               | No charge                                                   | No charge                                        | No charge                                                | <a href="#">Preauthorization</a> may be required to avoid a penalty of 50% up to a maximum deduction of \$2,500.                                                                                                                                                                                                         |
| If you are pregnant                                                       | Office visits                                    | No charge                                                   | No charge                                        | No charge                                                | <a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of services, a <a href="#">copay</a> , <a href="#">coinsurance</a> or <a href="#">deductible</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). |
|                                                                           | Childbirth/delivery professional services        | No charge                                                   | No charge                                        | No charge                                                |                                                                                                                                                                                                                                                                                                                          |
|                                                                           | Childbirth/delivery facility services            | No charge                                                   | No charge                                        | No charge                                                |                                                                                                                                                                                                                                                                                                                          |

| Common Medical Event                                                  | Services You May Need                     | What You Will Pay                                           |                                                  |                                                          | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                          |
|-----------------------------------------------------------------------|-------------------------------------------|-------------------------------------------------------------|--------------------------------------------------|----------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                       |                                           | Indian Health Care Provider (IHCP) (You will pay the least) | Non-IHCP In-Network Provider (You will pay more) | Non-IHCP Out-of-Network Provider (You will pay the most) |                                                                                                                                                                                                                                                                                                 |
| <b>If you need help recovering or have other special health needs</b> | <a href="#">Home health care</a>          | No charge                                                   | No charge                                        | No charge                                                | None.                                                                                                                                                                                                                                                                                           |
|                                                                       | <a href="#">Rehabilitation services</a>   | No charge                                                   | No charge                                        | No charge                                                | 20 sessions per year. Limits apply separately to outpatient rehabilitation and habilitation. The plan allows up to \$2,000 per day for out-of-network non-emergency admission. <a href="#">Preauthorization</a> may be required to avoid a penalty of 50% up to a maximum deduction of \$2,500. |
|                                                                       | <a href="#">Habilitation services</a>     | No charge                                                   | No charge                                        | No charge                                                |                                                                                                                                                                                                                                                                                                 |
|                                                                       | <a href="#">Skilled nursing care</a>      | No charge                                                   | No charge                                        | No charge                                                | Limited to 30 days per calendar year                                                                                                                                                                                                                                                            |
|                                                                       | <a href="#">Durable medical equipment</a> | No charge                                                   | No charge                                        | No charge                                                | Includes supplies and prosthetics. Frequency limits apply to some durable medical equipment (DME). <a href="#">Preauthorization</a> may be required to avoid a penalty of 50% up to a maximum deduction of \$2,500.                                                                             |
|                                                                       | <a href="#">Hospice services</a>          | No charge                                                   | No charge                                        | No charge                                                | <a href="#">Preauthorization</a> may be required to avoid a penalty of 50% up to a maximum deduction of \$2,500.                                                                                                                                                                                |
| <b>If your child needs dental or eye care</b>                         | Children's eye exam                       | No charge                                                   | No charge                                        | No charge                                                | Limited to one eye exam per calendar year for children under age 19. Additional in-network preventive eye <a href="#">screening</a> for children age 3-5 at no <a href="#">cost sharing</a> .                                                                                                   |
|                                                                       | Children's glasses                        | No charge                                                   | No charge                                        | No charge                                                | Coverage limited to one pair of glasses per calendar year for children under age 19.                                                                                                                                                                                                            |
|                                                                       | Children's dental check-up                | Not covered                                                 | 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](#).)

- |                                                                                                                                                                                                                                                                     |                                                                                                                                                                |                                                                                                                                                                                                |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"><li>• Abortion (except in cases of rape, incest, or when the life of the mother is endangered)</li><li>• Acupuncture</li><li>• Bariatric surgery</li><li>• Cosmetic surgery (except as required for certain situations)</li></ul> | <ul style="list-style-type: none"><li>• Dental care (Adult)</li><li>• Infertility treatment</li><li>• Long-term care</li><li>• Naturopathic supplies</li></ul> | <ul style="list-style-type: none"><li>• Non-emergency care when traveling outside the U.S.</li><li>• Private-duty nursing</li><li>• Routine foot care</li><li>• Weight loss programs</li></ul> |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- |                                                                                                    |                                                                                                                      |                                                                                                              |
|----------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"><li>• Chiropractic care, limited to 18 visits per year</li></ul> | <ul style="list-style-type: none"><li>• Hearing aids, limited to one hearing aid per ear every three years</li></ul> | <ul style="list-style-type: none"><li>• Routine eye care (Adult), limited to one eye exam per year</li></ul> |
|----------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------|

**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/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa>, Idaho Department of Insurance, 1-800-721-3272 or <https://doi.idaho.gov>, or contact Moda Health at 1-844-931-1775. Other coverage options may be available to you, too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about Your Health Idaho visit [www.yourhealthidaho.org](http://www.yourhealthidaho.org) or call 1-855-944-3246.

**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 on how 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 1-844-931-1775 or Idaho Department of Insurance at <https://doi.idaho.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? Not Applicable.

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, kwijijigo 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 <a href="#">plan's</a> overall <a href="#">deductible</a> | \$0 |
| ■ <a href="#">Specialist copayment</a>                          | \$0 |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 0%  |
| ■ Other <a href="#">coinsurance</a>                             | 0%  |

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*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,700</b> |
|---------------------------|-----------------|

In this example, Peg would pay:

| <i>Cost Sharing</i>               |             |
|-----------------------------------|-------------|
| <a href="#">Deductibles</a>       | \$0         |
| <a href="#">Copayments</a>        | \$0         |
| <a href="#">Coinsurance</a>       | \$0         |
| <i>What isn't covered</i>         |             |
| Limits or exclusions              | \$50        |
| <b>The total Peg would pay is</b> | <b>\$50</b> |

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

|                                                                 |     |
|-----------------------------------------------------------------|-----|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$0 |
| ■ <a href="#">Specialist copayment</a>                          | \$0 |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 0%  |
| ■ Other <a href="#">coinsurance</a>                             | 0%  |

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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$5,600</b> |
|---------------------------|----------------|

In this example, Joe would pay:

| <i>Cost Sharing</i>               |             |
|-----------------------------------|-------------|
| <a href="#">Deductibles</a>       | \$0         |
| <a href="#">Copayments</a>        | \$0         |
| <a href="#">Coinsurance</a>       | \$0         |
| <i>What isn't covered</i>         |             |
| Limits or exclusions              | \$20        |
| <b>The total Joe would pay is</b> | <b>\$20</b> |

### Mia's Simple Fracture

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

|                                                                 |     |
|-----------------------------------------------------------------|-----|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$0 |
| ■ <a href="#">Specialist copayment</a>                          | \$0 |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 0%  |
| ■ Other <a href="#">coinsurance</a>                             | 0%  |

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)  
[Diagnostic test](#) (*x-ray*)  
[Durable medical equipment](#) (*crutches*)  
[Rehabilitation services](#) (*physical therapy*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,800</b> |
|---------------------------|----------------|

In this example, Mia would pay:

| <i>Cost Sharing</i>               |            |
|-----------------------------------|------------|
| <a href="#">Deductibles</a>       | \$0        |
| <a href="#">Copayments</a>        | \$0        |
| <a href="#">Coinsurance</a>       | \$0        |
| <i>What isn't covered</i>         |            |
| Limits or exclusions              | \$0        |
| <b>The total Mia would pay is</b> | <b>\$0</b> |

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