

# 2027 Medical plan benefit summary



## ● Moda Select Idaho Gold 1250 + Vision Exam

|                                                | In network you pay                                                                                                                                                                                                                                                                              | Out-of-network you pay |
|------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------|
| <b>Calendar year costs</b>                     |                                                                                                                                                                                                                                                                                                 |                        |
| Deductible per person                          | \$1,250                                                                                                                                                                                                                                                                                         | \$2,500                |
| Deductible per family                          | \$2,500                                                                                                                                                                                                                                                                                         | \$5,000                |
| Out-of-pocket max per person                   | \$9,000                                                                                                                                                                                                                                                                                         | \$90,000               |
| Out-of-pocket max per family                   | \$18,000                                                                                                                                                                                                                                                                                        | \$180,000              |
| <b>Care &amp; services</b>                     |                                                                                                                                                                                                                                                                                                 |                        |
| Preventive care visit under the ACA            | 0%                                                                                                                                                                                                                                                                                              | 60% after deductible   |
| Primary care provider (PCP) office visit       | \$15/visit                                                                                                                                                                                                                                                                                      | 60% after deductible   |
| Specialist office visit                        | \$30/visit                                                                                                                                                                                                                                                                                      | 60% after deductible   |
| Urgent care visit                              | \$30/visit                                                                                                                                                                                                                                                                                      | 60% after deductible   |
| Virtual care visit – CirrusMD                  | 0%                                                                                                                                                                                                                                                                                              | Not applicable         |
| Other providers                                | \$5/visit                                                                                                                                                                                                                                                                                       | 60% after deductible   |
| Outpatient diagnostic X-ray & lab              | 15% after deductible                                                                                                                                                                                                                                                                            | 60% after deductible   |
| Emergency room visit                           | 15% after deductible                                                                                                                                                                                                                                                                            | 15% after deductible   |
| Ambulance                                      | 15% after deductible                                                                                                                                                                                                                                                                            | 15% after deductible   |
| Inpatient/outpatient Care                      | 15% after deductible                                                                                                                                                                                                                                                                            | 60% after deductible   |
| Behavioral health office visit                 | \$15/visit                                                                                                                                                                                                                                                                                      | 60% after deductible   |
| Physical, speech or occupational therapy visit | \$30/visit                                                                                                                                                                                                                                                                                      | 60% after deductible   |
| Spinal manipulation services                   | \$30/visit                                                                                                                                                                                                                                                                                      | 60% after deductible   |
| Dental services for under age 19               | Not covered                                                                                                                                                                                                                                                                                     | Not covered            |
| Vision exam for under age 19                   | 0%                                                                                                                                                                                                                                                                                              | 60%                    |
| Vision hardware for under age 19               | 0%                                                                                                                                                                                                                                                                                              | 60%                    |
| <b>Prescription medications</b>                |                                                                                                                                                                                                                                                                                                 |                        |
|                                                | One copay per 30-day supply.                                                                                                                                                                                                                                                                    |                        |
| Value                                          | \$5                                                                                                                                                                                                                                                                                             | \$5                    |
| Select                                         | \$10                                                                                                                                                                                                                                                                                            | \$10                   |
| Preferred                                      | 30% after deductible                                                                                                                                                                                                                                                                            | 30% after deductible   |
| Non-Preferred                                  | 50% after deductible                                                                                                                                                                                                                                                                            | 50% after deductible   |
| Preferred Specialty                            | 40% after deductible                                                                                                                                                                                                                                                                            | 40% after deductible   |
| Non-Preferred Specialty                        | 50% after deductible                                                                                                                                                                                                                                                                            | 50% after deductible   |
| <b>Features</b>                                |                                                                                                                                                                                                                                                                                                 |                        |
| Metallic level                                 | Gold                                                                                                                                                                                                                                                                                            |                        |
| Exchange                                       | On and Off                                                                                                                                                                                                                                                                                      |                        |
| Medicare Part D creditable                     | Yes                                                                                                                                                                                                                                                                                             |                        |
| Provider network                               | Moda Select                                                                                                                                                                                                                                                                                     |                        |
| Service area                                   | Ada, Adams, Bannock, Bear Lake, Benewah, Bingham, Boise, Bonner, Bonneville, Boundary, Canyon, Caribou, Cassia, Clearwater, Elmore, Franklin, Fremont, Gem, Idaho, Jefferson, Kootenai, Latah, Lewis, Madison, Minidoka, Nez Perce, Oneida, Owyhee, Payette, Power, Shoshone, Teton, Washington |                        |
| Additional benefit                             | Adult vision exam                                                                                                                                                                                                                                                                               |                        |

Limitations and exclusions apply. See the Summary of Benefits and Coverage (SBC) and the member handbook for the requirements, limitations and exclusions of the Plan. This document is provided for informational purposes only, and is intended for licensed and appointed producers of Moda Health. It is not an SBC and should not be regarded as a replacement for the SBC. If there is any discrepancy between the information in this summary and the contract, it is the contract that will control.