



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 1-844-931-1775. 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 or call 1-844-931-1775 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For network providers \$2,200 individual / \$4,400 family. Out-of-network providers \$4,400 individual / \$8,800 family.	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. For example: In-network preventive care , primary care, specialist , urgent care , virtual visits, outpatient behavioral health, outpatient rehabilitation and habilitation, as well as in and out of network children vision services and adult eye exams and prescription medications 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 network providers \$9,000 individual / \$18,000 family. Out-of-network providers \$90,000 individual / \$180,000 family.	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 , balance-billing charges, expenses incurred due to brand substitution, transplant expenses not performed at a center of excellence and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Will you pay less if you use a network provider?	Yes. See https://www.modahealth.com/ProviderSearch?productCategory=medical&selectedNetwork=Moda%20Select or call 1-844-931-1775 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.

Important Questions	Answers	Why This Matters:
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 copay /office visit, No charge/virtual care visit, No charge/CirrusMD virtual visit; deductible does not apply	60% coinsurance	None
	Specialist visit	\$30 copay /office visit, No charge/virtual care visit, No charge/CirrusMD virtual visit; deductible does not apply	60% coinsurance	Office visits by naturopaths and chiropractors are specialist visits.
	Preventive care/screening /immunization	No charge for most services. \$10 copay /visit, deductible does not apply or 10% coinsurance for remaining services.	60% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	60% coinsurance	Includes other tests such as EKG, allergy testing and sleep study. Preauthorization may be required to avoid a penalty of 50% up to a maximum deduction of \$2,500.
	Imaging (CT/PET scans, MRIs)	10% coinsurance	60% coinsurance	Preauthorization may be required to avoid a penalty of 50% up to a maximum deduction of \$2,500.

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 https://www.modahealth.com/pdl	Value tier	\$5 copay /retail prescription, \$15 copay /90-day retail and mail order prescription; deductible does not apply	\$5 copay /retail prescription, \$15 copay /90-day mail order prescription; deductible does not apply	Preauthorization may be required. Covers up to a 30-day supply (retail pharmacy) and 90-day supply (mail order and participating retail pharmacies). One copay for each 30-day supply. Mail order at a Moda Health designated mail order pharmacy or pharmacies that agree to follow our terms for mail order pharmacies. Covers up to a 30-day supply for most specialty. Cost sharing for anticancer medication is 10% coinsurance .
	Select tier	\$10 copay /retail prescription, \$30 copay /90-day retail and mail order prescription; deductible does not apply	\$10 copay /retail prescription, \$30 copay /90-day mail order prescription; deductible does not apply	
	Preferred tier	30% coinsurance ; deductible does not apply	30% coinsurance ; deductible does not apply	
	Non-preferred tier	50% coinsurance ; deductible does not apply	50% coinsurance ; deductible does not apply	
	Specialty drug tier	40% coinsurance for preferred, 50% coinsurance for non-preferred;	40% coinsurance for preferred, 50% coinsurance for non-preferred;	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	60% coinsurance	Preauthorization may be required to avoid a penalty of 50% up to a maximum deduction of \$2,500.
	Physician/surgeon fees	10% coinsurance	60% coinsurance	
If you need immediate medical attention	Emergency room care	10% coinsurance	10% coinsurance in-network deductible applies	None
	Emergency medical transportation	10% coinsurance	10% coinsurance in-network deductible applies	None
	Urgent care	\$30 copay /office visit, No charge/virtual care visit, No charge/CirrusMD virtual visit; deductible does not apply	60% coinsurance	None

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 have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	60% coinsurance	The plan allows up to \$2,000 per day for out-of-network non-emergency admission. Preauthorization may be required to avoid a penalty of 50% up to a maximum deduction of \$2,500.
	Physician/surgeon fees	10% coinsurance	60% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$10 copay /office visit and intensive outpatient visits, No charge/virtual care visit, No charge/CirrusMD virtual visit; deductible does not apply. 10% coinsurance for other outpatient services	60% coinsurance	Preauthorization may be required to avoid a penalty of 50% up to a maximum deduction of \$2,500.
	Inpatient services	10% coinsurance	60% coinsurance	Preauthorization 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	60% coinsurance	Cost sharing does not apply for preventive services . Depending on the type of services, a copay , 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	60% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	60% coinsurance	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	60% coinsurance	None.
	Rehabilitation services	\$30 copay /outpatient visit, deductible does not apply. 10% coinsurance for inpatient	60% coinsurance	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. Preauthorization may be required to avoid a penalty of 50% up to a maximum deduction of \$2,500.
	Habilitation services	\$30 copay /outpatient visit, deductible does not apply. 10% coinsurance for inpatient	60% 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 help recovering or have other special health needs	Skilled nursing care	10% coinsurance	60% coinsurance	Limited to 30 days per calendar year
	Durable medical equipment	10% coinsurance	60% coinsurance	Includes supplies and prosthetics. Frequency limits apply to some durable medical equipment (DME). Preauthorization may be required to avoid a penalty of 50% up to a maximum deduction of \$2,500.
	Hospice services	10% coinsurance	60% coinsurance	Preauthorization may be required to avoid a penalty of 50% up to a maximum deduction of \$2,500.
If your child needs dental or eye care	Children's eye exam	No charge	60% coinsurance deductible does not apply.	Limited to one eye exam per calendar year for children under age 19. Additional in-network preventive eye screening for children age 3-5 at no cost sharing .
	Children's glasses	No charge	60% coinsurance deductible does not apply.	Coverage limited to one pair of glasses per calendar year for children under age 19.
	Children's 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](#).)

- Abortion (except when the mother's life is at risk or the pregnancy is a result of rape or incest)
- Acupuncture
- Bariatric surgery
- Cosmetic surgery (except as required for certain situations)
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Naturopathic supplies
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

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

- Chiropractic care, limited to 18 visits per year
- Hearing aids, limited to one hearing aid per ear every three years for certain dependents
- Routine eye care (Adult), limited to one eye exam per year

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 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): Dinekehgo shika at'ohwol ninisingo, kwijigo 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	\$2,200
■ Specialist copayment	\$30
■ 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	\$12,700
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$2,200
Copayments	\$10*
Coinsurance	\$1,000*

<i>What isn't covered</i>	
Limits or exclusions	\$50
The total Peg would pay is	\$3,260*

Managing Joe's Type 2 Diabetes

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

■ The plan's overall deductible	\$2,200
■ Specialist copayment	\$30
■ 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	\$5,600
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$400
Copayments	\$200
Coinsurance	\$1,200

<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,820

Mia's Simple Fracture

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

■ The plan's overall deductible	\$2,200
■ Specialist copayment	\$30
■ 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	\$2,800
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$2,200
Copayments	\$100
Coinsurance	\$10

<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$2,310

*Note: These numbers assume a global charge. If your provider bills each service separately, these amounts may be different.

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