**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 1-844-248-7877. 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 1-844-248-7877 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | For network providers $1,000 individual / $2,000 family. Out-of-network providers $5,000 individual / $10,000 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 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 $7,500 individual / $15,000 family. Out-of-network providers $10,000 individual / $20,000 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 1-844-248-7877 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. |
| **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 | $5 copay/first 3 in person or virtual visits then $30 copay/visit for selected PCP in person, $50 copay/visit for other PCPs in person, $10 copay/virtual care visit, No charge/CirrusMD virtual visit for all visits; deductible does not apply | 50% coinsurance | First 3 visits combined with virtual care, mental health or substance use disorder office visits. |
| | Specialist visit | $50 copay/office visit, $30 copay/acupuncture and spinal manipulation visits, $10 copay/virtual care visit, No charge/CirrusMD virtual visit; deductible does not apply | 50% coinsurance | Office visits by naturopaths, acupuncturists and chiropractors are specialist visits. |
| | Preventive care/screening/ immunization | No charge for most services. $5 copay/visit for selected PCP, $50 copay/visit for other providers, 25% coinsurance for remaining services, deductible does not apply | 50% 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) | 25% coinsurance; deductible does not apply | 50% 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) | 25% coinsurance | 50% 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 | No charge | No charge | Preauthorization may be required.<br><br>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.<br><br>Covers up to a 30-day supply for most specialty.<br><br>Cost sharing for anticancer medication is 25% 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/mail order prescription; deductible does not apply | |
| | Preferred tier | $35 copay/retail prescription, $105 copay/90-day retail and mail order prescription; deductible does not apply | $35 copay/retail prescription, $105 copay/mail order prescription; deductible does not apply | |
| | Non-preferred tier | 50% coinsurance; deductible does not apply | 50% coinsurance; deductible does not apply | |
| | Specialty drug tier | 45% coinsurance for preferred, 50% coinsurance for non-preferred; deductible does not apply | 45% coinsurance for preferred, 50% coinsurance for non-preferred; deductible does not apply | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 25% coinsurance | 50% coinsurance | Preauthorization may be required to avoid a penalty of 50% up to a maximum deduction of $2,500. |
| | Physician/surgeon fees | 25% coinsurance | 50% coinsurance | |
| **If you need immediate medical attention** | Emergency room care | $350 copay/visit, then deductible, 25% coinsurance | $350 copay/visit, then deductible, 25% coinsurance in-network deductible applies | Copay waived if hospital admission immediately follows. |
| | Emergency medical transportation | 25% coinsurance | 25% coinsurance in-network deductible applies | None |
| | Urgent care | $50 copay/office visit, $10 copay/virtual care visit, No charge/CirrusMD virtual visit; deductible does not apply | 50% coinsurance | None |

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| 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) | 25% coinsurance | 50% coinsurance | Preauthorization may be required to avoid a penalty of 50% up to a maximum deduction of $2,500. |
| | Physician/surgeon fees | 25% coinsurance | 50% coinsurance | |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $5 copay/first 3 in person or virtual visits then<br>$30 copay/office visit and intensive outpatient visits,<br>$10 copay/virtual care visit,<br>No charge/CirrusMD virtual visit; deductible does not apply.<br>25% coinsurance for other outpatient services | 50% coinsurance | First 3 visits combined with virtual care and PCP office visits.<br><br>Preauthorization may be required to avoid a penalty of 50% up to a maximum deduction of $2,500. |
| | Inpatient services | 25% coinsurance | 50% 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 | $50 copay/visit<br>deductible does not apply. | 50% 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 | 25% coinsurance | 50% coinsurance | |
| | Childbirth/delivery facility services | 25% coinsurance | 50% coinsurance | |
| **If you need help recovering or have other special health needs** | Home health care | 25% coinsurance | 50% coinsurance | None. |
| | Rehabilitation services | $50 copay/outpatient visit, deductible does not apply.<br>25% coinsurance for inpatient | 50% coinsurance | 20 sessions per year. Limits apply separately to outpatient rehabilitation and habilitation. Preauthorization may be required to avoid a penalty of 50% up to a maximum deduction of $2,500. |
| | Habilitation services | $50 copay/outpatient visit, deductible does not apply.<br>25% coinsurance for inpatient | 50% coinsurance | |

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| 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 | 25% coinsurance | 50% coinsurance | Limited to 30 days per calendar year |
| | Durable medical equipment | 25% coinsurance | 50% 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 | 25% coinsurance | 50% 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 | 50% 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 | 50% 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)
- 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
- Routine eye care (Adult)

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

- Acupuncture, limited to 20 visits per year
- Chiropractic care, limited to 20 visits per year
- Hearing aids, limited to one hearing aid per ear every three years

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**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 1-844-248-7877. 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 1-844-248-7877 or Idaho Department of Insurance at https://doi.idaho.gov. 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.

**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, kwiijigo 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** **$1,000**
- **Specialist copayment** **$50**
- **Hospital (facility) coinsurance** **25%**
- **Other coinsurance** **25%**

**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** |
|---|---|

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $1,000 |
| Copayments | $10* |
| Coinsurance | $2,900* |
| *What isn't covered* | |
| Limits or exclusions | $50 |
| **The total Peg would pay is** | **$3,960*** |

### Managing Joe's Type 2 Diabetes

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

- **The plan's overall deductible** **$1,000**
- **Specialist copayment** **$50**
- **Hospital (facility) coinsurance** **25%**
- **Other coinsurance** **25%**

**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** |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $200 |
| Copayments | $1,200 |
| Coinsurance | $30 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$1,450** |

### Mia's Simple Fracture

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

- **The plan's overall deductible** **$1,000**
- **Specialist copayment** **$50**
- **Hospital (facility) coinsurance** **25%**
- **Other coinsurance** **25%**

**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** |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $1,000 |
| Copayments | $500 |
| Coinsurance | $200 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,700** |

*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.