

# 2026 Medical plan benefit summary

## ● Moda Select Idaho Silver 3000 + Vision Exam - AI/AN Limited

|                                                | Indian Health Care Provider (IHCP) you pay                                                                                                                                                                                                                                                          | Non-IHCP In-network you pay | Non-IHCP Out-of-network you pay |
|------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|---------------------------------|
| <b>Calendar year costs</b>                     |                                                                                                                                                                                                                                                                                                     |                             |                                 |
| Deductible per person                          | \$0                                                                                                                                                                                                                                                                                                 | \$3,000                     | \$6,000                         |
| Deductible per family                          | \$0                                                                                                                                                                                                                                                                                                 | \$6,000                     | \$12,000                        |
| Out-of-pocket max per person                   | \$0                                                                                                                                                                                                                                                                                                 | \$8,500                     | \$85,000                        |
| Out-of-pocket max per family                   | \$0                                                                                                                                                                                                                                                                                                 | \$17,000                    | \$170,000                       |
| <b>Care &amp; services</b>                     |                                                                                                                                                                                                                                                                                                     |                             |                                 |
| Preventive care visit                          | 0%                                                                                                                                                                                                                                                                                                  | \$0 per visit               | 60% after deductible            |
| Primary care provider (PCP) office visit       | 0%                                                                                                                                                                                                                                                                                                  | \$25 per visit              | 60% after deductible            |
| Specialist office visit                        | 0%                                                                                                                                                                                                                                                                                                  | \$70 per visit              | 60% after deductible            |
| Urgent care visit                              | 0%                                                                                                                                                                                                                                                                                                  | \$70 per visit              | 60% after deductible            |
| Virtual care visit – CirrusMD                  | N/A                                                                                                                                                                                                                                                                                                 | \$0 per visit               | N/A                             |
| Other providers                                | 0%                                                                                                                                                                                                                                                                                                  | \$15 per visit              | 60% after deductible            |
| Outpatient diagnostic X-ray & lab              | 0%                                                                                                                                                                                                                                                                                                  | 35% after deductible        | 60% after deductible            |
| Emergency room visit                           | 0%                                                                                                                                                                                                                                                                                                  | 35% after deductible        | 35% after deductible            |
| Ambulance                                      | 0%                                                                                                                                                                                                                                                                                                  | 35% after deductible        | 35% after deductible            |
| Inpatient/outpatient care                      | 0%                                                                                                                                                                                                                                                                                                  | 35% after deductible        | 60% after deductible            |
| Behavioral health office visit                 | 0%                                                                                                                                                                                                                                                                                                  | \$25 per visit              | 60% after deductible            |
| Physical, speech or occupational therapy visit | 0%                                                                                                                                                                                                                                                                                                  | \$70 per visit              | 60% after deductible            |
| Spinal manipulation services                   | 0%                                                                                                                                                                                                                                                                                                  | \$70 per visit              | 60% after deductible            |
| Dental services for under age 19               | Not covered                                                                                                                                                                                                                                                                                         | Not covered                 | Not covered                     |
| Vision exam for under age 19                   | 0%                                                                                                                                                                                                                                                                                                  | \$0 per visit               | 60%                             |
| Vision hardware for under age 19               | 0%                                                                                                                                                                                                                                                                                                  | 0%                          | 60%                             |
| Adult vision exam                              | 0%                                                                                                                                                                                                                                                                                                  | \$10 per visit              | 60%                             |
| <b>Prescription medications</b>                |                                                                                                                                                                                                                                                                                                     |                             |                                 |
|                                                | One copay for a 30-day supply                                                                                                                                                                                                                                                                       |                             |                                 |
| Value                                          | 0%                                                                                                                                                                                                                                                                                                  | \$2                         | \$2                             |
| Select                                         | 0%                                                                                                                                                                                                                                                                                                  | \$20                        | \$20                            |
| Preferred                                      | 0%                                                                                                                                                                                                                                                                                                  | 40% after deductible        | 40% after deductible            |
| Non-Preferred                                  | 0%                                                                                                                                                                                                                                                                                                  | 50% after deductible        | 50% after deductible            |
| Preferred Specialty                            | 0%                                                                                                                                                                                                                                                                                                  | 40% after deductible        | 40% after deductible            |
| Non-Preferred Specialty                        | 0%                                                                                                                                                                                                                                                                                                  | 50% after deductible        | 50% after deductible            |
| <b>Features</b>                                |                                                                                                                                                                                                                                                                                                     |                             |                                 |
| Metallic level                                 | ● Silver                                                                                                                                                                                                                                                                                            |                             |                                 |
| Exchange                                       | On                                                                                                                                                                                                                                                                                                  |                             |                                 |
| Medicare Part D creditable                     | Creditable                                                                                                                                                                                                                                                                                          |                             |                                 |
| Provider network                               | Moda Select                                                                                                                                                                                                                                                                                         |                             |                                 |
| Other network                                  | Aetna® PPO Network                                                                                                                                                                                                                                                                                  |                             |                                 |
| 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, and Washington |                             |                                 |

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.