



! Required filings that relate to these 2026 plans are currently under review by the applicable regulatory agencies and are subject to change until approved.

	Gold plans		Silver plans			Bronze plans		
	Moda Select Idaho Gold 1100 + Vision Exam	Moda Select Idaho Gold 2200 + Vision Exam	Moda Select Idaho Silver 3000 + Vision Exam	Moda Select Idaho Silver 4000 + Vision Exam	Moda Select Idaho Silver 6400 + Vision Exam	Moda Select Idaho Bronze 9200 + Vision Exam	Moda Select Idaho Bronze 10,000 + Vision Exam	Moda Select Idaho Bronze HDHP 7500

What you pay for the *in-network* care you receive each year

Deductible per person	\$1,100	\$2,200	\$3,000	\$4,000	\$6,400	\$9,200	\$10,000	\$7,500
Deductible per family	\$2,200	\$4,400	\$6,000	\$8,000	\$12,800	\$18,400	\$20,000	\$15,000
Out-of-pocket max per person	\$8,000	\$7,600	\$8,500	\$8,900	\$7,400	\$9,500	\$10,000	\$7,500
Out-of-pocket max per family	\$16,000	\$15,200	\$17,000	\$17,800	\$14,800	\$19,000	\$20,000	\$15,000
Out-of-network benefits available	✓	✓	✓	✓	✓	✓	✓	✓

Benefits that make up your plan and what you pay

Primary Care Provider (PCP) office visit	\$15 per visit	\$10 per visit	\$25 per visit	\$10 per visit	\$25 per visit	\$50 per visit	\$50 per visit	0% after deductible
Specialist office visit	\$30 per visit	\$30 per visit	\$70 per visit	\$50 per visit	\$70 per visit	\$100 per visit	\$125 per visit	0% after deductible
Urgent care visit	\$30 per visit	\$30 per visit	\$70 per visit	\$50 per visit	\$70 per visit	\$100 per visit	\$125 per visit	0% after deductible
Virtual care visit	\$5 per visit	\$0 per visit	\$15 per visit	\$5 per visit	\$15 per visit	\$40 per visit	\$40 per visit	0% after deductible
Outpatient diagnostic X-ray and lab	15% after deductible	10% after deductible	35% after deductible	\$60 per day per provider	35% after deductible	25% after deductible	\$75 per day per provider	0% after deductible
Emergency room visit	15% after deductible	10% after deductible	35% after deductible	\$400 after deductible	35% after deductible	25% after deductible	0% after deductible	0% after deductible
Spinal manipulation services	\$30 per visit	\$30 per visit	\$70 per visit	\$50 per visit	\$70 per visit	\$100 per visit	\$125 per visit	0% after deductible
Behavioral health office visit	\$15 per visit	\$10 per visit	\$25 per visit	\$10 per visit	\$25 per visit	\$50 per visit	\$50 per visit	0% after deductible
Physical, speech or occupational therapy visit	\$30 per visit	\$30 per visit	\$70 per visit	\$50 per visit	\$70 per visit	25% after deductible	0% after deductible	0% after deductible
Inpatient/outpatient care	15% after deductible	10% after deductible	35% after deductible	40% after deductible	35% after deductible	25% after deductible	0% after deductible	0% after deductible

Prescription medication¹

Value	\$2	\$2	\$2	\$2	\$2	\$2	\$2	0%
Select	\$10	\$5	\$20	\$20	\$20	\$25	\$20	0% after deductible
Preferred	30% after deductible	30%	40% after deductible	40%	40%	40%	40%	0% after deductible
Non-Preferred	50% after deductible	50%	50% after deductible	50% after deductible	50% after deductible	50% after deductible	50% after deductible	0% after deductible
Preferred Specialty	30% after deductible	30%	40% after deductible	40%	40%	40%	40%	0% after deductible
Non-Preferred Specialty	50% after deductible	50%	50% after deductible	50% after deductible	50% after deductible	50% after deductible	50% after deductible	0% after deductible

Things to consider when choosing your plan

Features and special benefits included in your plan	PCP +	PCP +	PCP +	PCP +	PCP +	PCP +	PCP +	PCP HSA +
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¹ One copay per 30-day supply

Plan highlights

- PCP** Choose a PCP
To help you manage your health, we highly encourage selecting an in-network PCP
- ✓** Out-of-network available
For out-of-network benefits, scan the QR code, then click on Idaho to view Summaries of Benefits and Coverage (SBCs) with detailed information on each plan.
- HSA** Health savings account (HSA)
Our HSA-compatible, high-deductible health plan (Bronze HDHP 7500) gives you flexibility and choice. You have the freedom to choose any financial institution for your HSA. You can use HSA tax-free dollars to pay for deductibles, coinsurance and other qualified expenses not covered by your health plan.



- +** Included with *all* plans:
- 🧠** Unlimited mental health and substance use disorder in-person office visits
- PT** Rehabilitation and habilitation benefits (physical, occupational and speech therapy) limited to separate 20 sessions per year
- 🏠** Spinal manipulation limited to 18 visits per year
- 👶** Pediatric vision for under age 19, including vision exam, glasses, lenses or contacts once per calendar year

These benefits and Moda Health Plan policies are subject to change in order to be compliant with state and federal guidelines. This document provides summaries of various health plans and is not a contract. If there is any discrepancy between the summaries and the contract, it is the contract that will control.



Save more

In addition to a tax credit, members may be eligible for a **cost-sharing reduction plan** that lowers the amount paid out-of-pocket for deductibles, coinsurance, and copays. Members of federally recognized American Indian and Alaska Native tribes may also qualify for additional cost-sharing benefits.

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2026 Cost-sharing reduction (CSR) plans

	Moda Select Idaho Silver 3000 + Vision Exam			Moda Select Idaho Silver 4000 + Vision Exam			Moda Select Idaho Silver 6400 + Vision Exam		
	73% CSR	87% CSR	94% CSR	73% CSR	87% CSR	94% CSR	73% CSR	87% CSR	94% CSR

What you pay for the *in-network* care you receive each year

Deductible per person	\$2,900	\$900	\$500	\$4,000	\$1,000	\$0	\$3,500	\$1,000	\$500
Deductible per family	\$5,800	\$1,800	\$1,000	\$8,000	\$2,000	\$0	\$7,000	\$2,000	\$1,000
Out-of-pocket max per person	\$6,950	\$2,475	\$750	\$7,500	\$2,300	\$1,000	\$6,450	\$2,500	\$750
Out-of-pocket max per family	\$13,900	\$4,950	\$1,500	\$15,000	\$4,600	\$2,000	\$12,900	\$5,000	\$1,500
Out-of-network benefits available	✔️	✔️	✔️	✔️	✔️	✔️	✔️	✔️	✔️

Benefits that make up your plan and what you pay

Primary Care Provider (PCP) office visit	\$25 per visit	\$20 per visit	\$10 per visit	\$5 per visit	\$5 per visit	\$5 per visit	\$25 per visit	\$20 per visit	\$10 per visit
Specialist office visit	\$70 per visit	\$40 per visit	\$20 per visit	\$50 per visit	\$40 per visit	\$15 per visit	\$70 per visit	\$40 per visit	\$20 per visit
Urgent care visit	\$70 per visit	\$40 per visit	\$20 per visit	\$50 per visit	\$40 per visit	\$15 per visit	\$70 per visit	\$40 per visit	\$20 per visit
Virtual care visit	\$15 per visit	\$10 per visit	\$5 per visit	\$0 per visit	\$0 per visit	\$0 per visit	\$15 per visit	\$10 per visit	\$5 per visit
Outpatient diagnostic X-ray and lab	35% after deductible	35% after deductible	35% after deductible	\$60 per day per provider	\$60 per day per provider	\$60 per day per provider	35% after deductible	35% after deductible	35% after deductible
Emergency room visit	35% after deductible	35% after deductible	35% after deductible	\$350 after deductible	\$300 after deductible	\$150	35% after deductible	35% after deductible	35% after deductible
Spinal manipulation services	\$70 per visit	\$40 per visit	\$20 per visit	\$50 per visit	\$40 per visit	\$15 per visit	\$70 per visit	\$40 per visit	\$20 per visit
Behavioral health office visit	\$25 per visit	\$20 per visit	\$10 per visit	\$5 per visit	\$5 per visit	\$5 per visit	\$25 per visit	\$20 per visit	\$10 per visit
Physical, speech or occupational therapy visit	\$70 per visit	\$40 per visit	\$20 per visit	\$50 per visit	\$40 per visit	\$15 per visit	\$70 per visit	\$40 per visit	\$20 per visit
Inpatient/outpatient care	35% after deductible	35% after deductible	35% after deductible	40% after deductible	30% after deductible	20%	35% after deductible	35% after deductible	35% after deductible

Prescription medication¹

Value	\$2	\$2	\$2	\$2	\$2	\$2	\$2	\$2	\$2
Select	\$20	\$20	\$10	\$20	\$20	\$10	\$20	\$20	\$10
Preferred	40% after deductible	40% after deductible	40% after deductible	40%	40%	40%	40%	40%	40%
Non-Preferred	50% after deductible	50% after deductible	50% after deductible	50% after deductible	50% after deductible	50%	50% after deductible	50% after deductible	50% after deductible
Preferred Specialty	40% after deductible	40% after deductible	40% after deductible	40%	40%	40%	40%	40%	40%
Non-Preferred Specialty	50% after deductible	50% after deductible	50% after deductible	50% after deductible	50% after deductible	50%	50% after deductible	50% after deductible	50% after deductible

Things to consider when choosing your plan

Features and special benefits included in your plan	PCP +	PCP +	PCP +	PCP +	PCP +	PCP +	PCP +	PCP +	PCP +
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¹ One copay for a 30-day supply

These benefits and Moda Health Plan policies are subject to change in order to be compliant with state and federal guidelines. This document provides summaries of various health plans and is not a contract. If there is any discrepancy between the summaries and the contract, it is the contract that will control.

Limitations & exclusions

Limitations

- Authorization by Moda Health is required for all medical and surgical admissions and some outpatient services and medications
- Biofeedback is limited to 10 visits per lifetime for tension or migraine headaches
- Brand tier medications – if members use a brand medication when a generic equivalent is available, they will have to pay the non-preferred cost sharing plus the difference in cost between the generic and brand medication
- Coordination of Benefits – when a member has more than one health plan, combined benefits for all plans is limited to the maximum plan allowance for all covered services
- Hearing aids are covered one aid per ear every 3 years for children with certain medical conditions
- Hospital stay and inpatient rehabilitation benefits are limited to \$2,000 per day for out-of-network non-emergency admission
- Infusion therapy – some medications require use of an authorized provider to be eligible for coverage. Outpatient hospital setting is not covered for some medications.
- Prescriptions are limited to a maximum 30-day supply per prescription for most specialty pharmacy and up to a 90-day supply per prescription for retail and mail order pharmacies
- Preventive care – cost sharing may apply to services not required under the Affordable Care Act
- Rehabilitation and habilitation benefits include separate limits of 20 outpatient sessions per year
- Skilled nursing facility is limited to 30 days per year
- Spinal manipulation is limited to 18 visits per year
- Vision exam and glasses or contacts are covered once per year for members under age 19
- Adult vision exam once per year

Exclusions

- Abortion, except the mother's life is at risk or the pregnancy is a result of rape or incest
- Acupuncture
- Care outside the United States, other than emergency care
- Charges above the maximum plan allowance
- Cosmetic services and supplies (exception for reconstructive surgery if medically necessary and not specifically excluded)
- Court-ordered sex offender treatment
- Custodial care
- Dental examinations and treatment (except for accidental injury)
- Experimental or investigational treatment
- Faith healing
- Infertility (services or supplies for treatment of, including reversal of sterilization)
- Injury resulting from practicing for or participating in professional athletic events
- Instruction programs, except as provided under the outpatient diabetic instruction benefit
- Massage or massage therapy
- Naturopathic supplies, including herbal, homeopathic medicines, substances or devices and any other nonprescription supplements
- Obesity (all services and supplies except those required under the Affordable Care Act)
- Optional services or supplies, including those for comfort, convenience, environmental control or education, and treatment not medically necessary
- Orthognathic surgery, except when medically necessary to repair an accidental injury or for treatment of cancer
- Services or supplies available under any city, county, state or federal law, except Medicaid
- Services ordered or provided by the patient or a member of the patient's immediate family
- Temporomandibular Joint Syndrome (TMJ)
- Vision surgery to alter the refractive character of the eye