

# 2027 Medical plan benefit summary



## ● Moda Pathways Oregon Bronze 9000 - AI/AN Limited

|                                                 | Indian Health Care Provider (IHCP) you pay                               | In-network you pay   | Out-of-network you pay |
|-------------------------------------------------|--------------------------------------------------------------------------|----------------------|------------------------|
| <b>Calendar year costs</b>                      |                                                                          |                      |                        |
| Deductible per person                           | \$0                                                                      | \$9,000              | Not covered            |
| Deductible per family                           | \$0                                                                      | \$18,000             | Not covered            |
| Out-of-pocket max per person                    | \$0                                                                      | \$12,000             | Not covered            |
| Out-of-pocket max per family                    | \$0                                                                      | \$24,000             | Not covered            |
| <b>Care &amp; services</b>                      |                                                                          |                      |                        |
| Preventive care visit under the ACA             | 0%                                                                       | 0%                   | Not covered            |
| Primary care provider (PCP) office visit        | 0%                                                                       | \$80/visit           | Not covered            |
| Specialist office visit                         | 0%                                                                       | \$135/visit          | Not covered            |
| Urgent care visit                               | 0%                                                                       | \$135/visit          | Not covered            |
| Virtual care visit - CirrusMD                   | Not applicable                                                           | 0%                   | Not applicable         |
| Other providers                                 | 0%                                                                       | \$10/visit           | Not covered            |
| Outpatient diagnostic X-ray & lab               | 0%                                                                       | 20% after deductible | Not covered            |
| Emergency room visit                            | 0%                                                                       | 20% after deductible | 20% after deductible   |
| Ambulance                                       | 0%                                                                       | 20% after deductible | 20% after deductible   |
| Inpatient/outpatient care                       | 0%                                                                       | 20% after deductible | Not covered            |
| Behavioral health office visit                  | 0%                                                                       | \$80/visit           | Not covered            |
| Physical, speech or occupational therapy visit  | 0%                                                                       | \$135/visit          | Not covered            |
| Acupuncture and spinal manipulation services    | 0%                                                                       | \$80/visit           | Not covered            |
| Dental services for under age 19                | Not covered                                                              | Not covered          | Not covered            |
| Vision exam for under age 19                    | 0%                                                                       | 0%                   | Not covered            |
| Vision hardware for under age 19                | 0%                                                                       | 0%                   | Not covered            |
| <b>Prescription medications</b>                 |                                                                          |                      |                        |
|                                                 | One copay per 30-day supply. \$35 maximum per 30-day supply for insulin. |                      |                        |
| Value                                           | \$0                                                                      | \$15                 | \$15                   |
| Select                                          | \$0                                                                      | \$15                 | \$15                   |
| Preferred                                       | \$0                                                                      | 40% after deductible | 40% after deductible   |
| Non-Preferred                                   | \$0                                                                      | 50% after deductible | 50% after deductible   |
| Preferred Specialty                             | \$0                                                                      | 45% after deductible | Not covered            |
| Non-Preferred Specialty                         | \$0                                                                      | 50% after deductible | Not covered            |
| <b>Features</b>                                 |                                                                          |                      |                        |
| Metallic level                                  | Expanded Bronze                                                          |                      |                        |
| Exchange                                        | On                                                                       |                      |                        |
| Medicare Part D creditable                      | No                                                                       |                      |                        |
| Provider network                                | Moda Pathways Network                                                    |                      |                        |
| Service area                                    | Clackamas, Multnomah, Washington                                         |                      |                        |
| Additional benefit (not covered out-of-network) | Includes adult vision exam and hearing exam/hearing aid                  |                      |                        |

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.