

# 2026 Medical plan benefit summary



## ● Moda Health Oregon Standard Gold

|                                                                                        | In network you pay                                                                                                                   | Out-of-network you pay |
|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|------------------------|
| <b>Calendar year costs</b>                                                             |                                                                                                                                      |                        |
| Deductible per person                                                                  | \$1,800                                                                                                                              | \$3,600                |
| Deductible per family                                                                  | \$3,600                                                                                                                              | \$7,200                |
| Out-of-pocket max per person                                                           | \$8,150                                                                                                                              | \$16,300               |
| Out-of-pocket max per family                                                           | \$16,300                                                                                                                             | \$32,600               |
| <b>Care &amp; services</b>                                                             |                                                                                                                                      |                        |
| Preventive care under the ACA<br>(out-of-network for select services)                  | \$0/visit                                                                                                                            | 50% after deductible   |
| Primary care provider (PCP) office visit                                               | \$20/visit                                                                                                                           | 50% after deductible   |
| First 3 in-person or virtual PCP,<br>naturopath and behavioral health<br>office visits | \$5/visit                                                                                                                            | 50% after deductible   |
| Specialist office visit                                                                | \$40/visit                                                                                                                           | 50% after deductible   |
| Urgent care visit                                                                      | \$60/visit                                                                                                                           | 50% after deductible   |
| Virtual care visit – CirrusMD                                                          | \$20/visit                                                                                                                           | N/A                    |
| Other providers                                                                        | \$20/visit                                                                                                                           | 50% after deductible   |
| Outpatient diagnostic X-ray & lab                                                      | 20% after deductible                                                                                                                 | 50% after deductible   |
| Emergency room visit                                                                   | 20% after deductible                                                                                                                 | 20% after deductible   |
| Ambulance                                                                              | 20% after deductible                                                                                                                 | 20% after deductible   |
| Inpatient/outpatient Care                                                              | 20% after deductible                                                                                                                 | 50% after deductible   |
| Behavioral health office visit                                                         | \$20/visit                                                                                                                           | 50% after deductible   |
| Physical, speech or<br>occupational therapy visit                                      | \$20/visit                                                                                                                           | 50% after deductible   |
| Acupuncture and<br>spinal manipulation services                                        | \$20/visit                                                                                                                           | 50% after deductible   |
| Pediatric vision exam                                                                  | \$0/visit                                                                                                                            | 0%                     |
| Pediatric vision hardware                                                              | 0%                                                                                                                                   | 0%                     |
| Prescription medications                                                               | (One copay for a 30-day supply. \$35 maximum per 30-day supply for insulin)<br>\$500 maximum per 30-day specialty prescription fill. |                        |
| Value                                                                                  | \$10                                                                                                                                 | \$10                   |
| Select                                                                                 | \$10                                                                                                                                 | \$10                   |
| Preferred                                                                              | \$30                                                                                                                                 | \$30                   |
| Non-Preferred                                                                          | 50%                                                                                                                                  | 50%                    |
| Preferred Specialty                                                                    | 50%                                                                                                                                  | Not Covered            |
| Non-Preferred Specialty                                                                | 50%                                                                                                                                  | Not Covered            |
| <b>Features</b>                                                                        |                                                                                                                                      |                        |
| Metallic level                                                                         | Gold                                                                                                                                 |                        |
| Exchange                                                                               | Off                                                                                                                                  |                        |
| Medicare Part D creditable                                                             | Creditable                                                                                                                           |                        |
| Provider network                                                                       | Connexus                                                                                                                             |                        |
| Service area                                                                           | Statewide                                                                                                                            |                        |

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.