Health plans for every body

Moda Health Plan, Inc. (Moda Health) is thrilled to offer health plans that help you and your employees find a way to better health.

You know your employees' health relies on quality plans, programs, online tools and, most important, partnerships to help them along the way. We have all of that and a little bit more. We're excited to help your entire group start on a journey to be better.

About Moda Health

Our health plans are designed to fit your employees' lifestyle, so they can get well sooner and live well longer. For our part, we'll provide:

- A diverse network of doctors and specialists in our First Choice Health PPO network and ODS Plus network.
- Expert health coaches, caring customer service reps and leading innovators in healthcare.
- A passionate commitment to rigorous service and clinical quality standards — like the NCQA commendable accreditation we earned for our quality PPO plans in Washington.
- A personal touch. We'll connect your team with digital tools and real humans who have never heard the term phone tree.

For your part, we ask that each member of your group comes ready to be the MVP of his or her health. Don't worry; we'll help inspire them.

Discover more ways to be better

When you choose Moda Health, you get innovative plan designs, cost-effective benefits, and exceptional customer service. You'll also appreciate partnering with a company that has national expertise and deep ties in the Pacific Northwest. Simply put:

We help you find the right care, at the right time, in the right place — and at the right price. In Moda Health, you'll find a passionate partner to support your healthcare goals. Here's what else you can count on:

- A pioneer in pharmacy services, with hundreds of thousands of members throughout Oregon, Washington and Alaska.
- A multi-faceted organization with a healthcare network serving business clients from Seattle to Spokane, from Ashland to Anchorage, and beyond.
- An online innovator with a wide range of free tools and programs to help you better manage your health.
- A team of health experts — doctors, nurses, counselors, pharmacists and coaches — who will make sure you get the most from your health plan.

7244320 (7/14) SS-1542

moda HEALTH

Effective January 1, 2015

Prime plans	Prime 0 - 90/70 0/10/90%		Prime 0 - 80/60 0/15/80%		Prime 250 - 90/70 250/15/90%		Prime 250 - 80/60 250/20/80%		Prime 500+ 500/20/80%	
	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network
Calendar year costs										
Annual Deductible *Family 2X Individual	$0	$300	$0	$500	$250	$500	$250	$500	$500	$1,000
Maximum Out-of-Pocket with Deductible *Family 2X Individual	$1,500	$2,300	$2,000	$4,000	$1,500	$3,000	$2,250	$4,500	$2,500	$5,000
Maximum Policy Benefit per Covered Person (Combined Network/Out-of-Network)	Unlimited		Unlimited		Unlimited		Unlimited		Unlimited	
Out-of-Network Coinsurance	70%		60%		70%		60%		60%	
Preventive Care (Most out-of-network preventive services are not covered)										
Office Visit	100%		100%		100%*		100%*		100%*	
Lab, X-ray and preventive test	90%		80%		90%		80%		80%	
Emergency/Urgent Care										
Ambulance Services	90%		80%		90%		80%		80%	
Emergency Health Services - Outpatient	$100		$100		$100*		$150*		$150*	
Urgent Care Office Visits	$50		$50		$50*		$75*		$75*	
Professional Care/Diagnostics										
Office Visit	$10		$15		$15*		$20*		$20*	
Vision Exams (Limited to one per year from a Network Provider)	$10		$15		$15*		$20*		$20*	
Professional Fees Surgical and Medical Services	90%		80%		90%		80%		80%	
Outpatient Surgery, Diagnostic and Therapeutic Services										
Surgery	90%		80%		90%		80%		80%	
Outpatient Diagnostic and Lab	100%		100%		100%*		100%*		100%*	
CT Scans, PET Scans, MRI and Nuclear Medicine	90%		80%		90%		80%		80%	
Outpatient Therapeutic Treatments	90%		80%		90%		80%		80%	
Facility Care										
Hospital - Inpatient Stay	90%		80%		90%		80%		80%	
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services (Limited to 60 days per year)	90%		80%		90%		80%		80%	
Hospice Care	90%		80%		90%		80%		80%	
Additional Benefits										
Acupuncture Services (Limited to 10 visits per year)	$10		$15		$15*		$20*		$20*	
Durable Medical Equipment (Subject to frequency limits)	90%		80%		90%		80%		80%	
Hearing Aids	90%		80%		90%		80%		80%	
Home Health Care (Limited to 130 home health care services per year)	90%		80%		90%		80%		80%	
Prosthetic Devices	90%		80%		90%		80%		80%	
Transplantation Services	90%		80%		90%		80%		80%	
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment (Includes Neurodevelopmental Therapy)**	$10		$15		$15*		$20*		$20*	
Mental Health Services and Substance Use Disorder Services										
Outpatient	$10		$15		$15*		$20*		$20*	
Inpatient, Residential and Partial Hospitalization	90%		80%		90%		80%		80%	

Rx plan choice	$2 / $10 / $30 / $50

Eligible Flex Plans are denoted with the + symbol
Rx deductibles and copays apply to the in-network annual coinsurance maximum.
Benefits are calculated on a calendar year.

** Deductible waived*
*** Plans are limited to 20 visits of physical therapy; 20 visits of occupational therapy; 20 visits of speech therapy; 24 visits of manipulative treatment; 20 visits of massage therapy; 20 visits of pulmonary rehabilitation; 36 visits of cardiac rehabilitation; and 30 visits of post-cochlear implant aural therapy per year.*

Effective January 1, 2015

Prime plans (continued)	Prime 750 750/20/80%		Prime 1000+ 1000/25/80%		Prime 1500 1500/30/80%		Prime 2000 2000/35/80%	
	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network
Calendar year costs								
Annual Deductible *Family 2X Individual	$750	$1,500	$1,000	$2,000	$1,500	$3,000	$2,000	$4,000
Maximum Out-of-Pocket with Deductible *Family 2X Individual	$2,750	$5,500	$3,000	$6,000	$4,000	$8,000	$5,000	$10,000
Maximum Policy Benefit per Covered Person (Combined Network/Out-of-Network)	Unlimited		Unlimited		Unlimited		Unlimited	
Out-of-Network Coinsurance	60%		60%		60%		60%	
Preventive Care (Most out-of-network preventive services are not covered)								
Office Visit	100%*		100%*		100%*		100%*	
Lab, X-ray and preventive test	80%		80%		80%		80%	
Emergency/Urgent Care								
Ambulance Services	80%		80%		80%		80%	
Emergency Health Services - Outpatient	$150*		$150*		$150*		$150*	
Urgent Care Office Visits	$75*		$75*		$75*		$75*	
Professional Care/Diagnostics								
Office Visit	$20*		$25*		$30*		$35*	
Vision Exams (Limited to one per year from a Network Provider)	$20*		$25*		$30*		$35*	
Professional Fees Surgical and Medical Services	80%		80%		80%		80%	
Outpatient Surgery, Diagnostic and Therapeutic Services								
Surgery	80%		80%		80%		80%	
Outpatient Diagnostic and Lab	100%*		100%*		100%*		100%*	
CT Scans, PET Scans, MRI and Nuclear Medicine	80%		80%		80%		80%	
Outpatient Therapeutic Treatments	80%		80%		80%		80%	
Facility Care								
Hospital - Inpatient Stay	80%		80%		80%		80%	
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services (Limited to 60 days per year)	80%		80%		80%		80%	
Hospice Care	80%		80%		80%		80%	
Additional Benefits								
Acupuncture Services (Limited to 10 visits per year)	$20*		$25*		$30*		$35*	
Durable Medical Equipment (Subject to frequency limits)	80%		80%		80%		80%	
Hearing Aids	80%		80%		80%		80%	
Home Health Care (Limited to 130 home health care services per year)	80%		80%		80%		80%	
Prosthetic Devices	80%		80%		80%		80%	
Transplantation Services	80%		80%		80%		80%	
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment (Includes Neurodevelopmental Therapy)**	$20*		$25*		$30*		$35*	
Mental Health Services and Substance Use Disorder Services								
Outpatient	$20*		$25*		$30*		$35*	
Inpatient, Residential and Partial Hospitalization	80%		80%		80%		80%	

Rx plan choice	$2 / $10 / $30 / $50

Eligible Flex Plans are denoted with the + symbol
Rx deductibles and copays apply to the in-network annual coinsurance maximum.
Benefits are calculated on a calendar year.

** Deductible waived*
*** Plans are limited to 20 visits of physical therapy; 20 visits of occupational therapy; 20 visits of speech therapy; 24 visits of manipulative treatment; 20 visits of massage therapy; 20 visits of pulmonary rehabilitation; 36 visits of cardiac rehabilitation; and 30 visits of post-cochlear implant aural therapy per year.*

moda HEALTH

Effective January 1, 2015

Select plans	Select 250 250/20/80%		Select 500 500/25/80%		Select 1000 1000/30/80%	
	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network
Calendar year costs						
Annual Deductible *Family 2X Individual (except for HSA Plan)	$250	$500	$500	$1,000	$1,000	$2,000
Maximum Out-of-Pocket with Deductible *Family 2X Individual	$2,750	$5,500	$3,500	$7,000	$4,000	$8,000
Maximum Policy Benefit per Covered Person (Combined Network/Out-of-Network)	Unlimited		Unlimited		Unlimited	
Out-of-Network Coinsurance	50%		50%		50%	
Preventive Care (Most out-of-network preventive services are not covered)						
Office Visit	100%*		100%*		100%*	
Lab, X-ray and preventive test	80%		80%		80%	
Emergency/Urgent Care						
Ambulance Services	80%		80%		80%	
Emergency Health Services - Outpatient per visit	$200, then 80%*		$200, then 80%*		$200, then 80%*	
Emergency Health Services - Outpatient others	80%		80%		80%	
Professional Care/Diagnostics						
Office Visit	$20*		$25*		$30*	
Urgent Care Office Visits	$20*		$25*		$30*	
Vision Exams (Limited to one per year from a Network Provider)	$20*		$25*		$30*	
Professional Fees Surgical and Medical Services	80%		80%		80%	
Outpatient Surgery, Diagnostic and Therapeutic Services						
Surgery	80%		80%		80%	
Outpatient Diagnostic and Lab	80%		80%		80%	
CT Scans, PET Scans, MRI and Nuclear Medicine	80%		80%		80%	
Outpatient Therapeutic Treatments	80%		80%		80%	
Facility Care						
Hospital - Inpatient Stay	80%		80%		80%	
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services (Limited to 90 days per year)	80%		80%		80%	
Hospice Care	80%		80%		80%	
Additional Benefits						
Acupuncture Services (Limited to 12 visits per year)	$20*		$25*		$30*	
Durable Medical Equipment (Subject to frequency limits)	80%		80%		80%	
Hearing Aids	80%		80%		80%	
Home Health Care (Limited to 130 home health care services per year)	80%		80%		80%	
Prosthetic Devices	80%		80%		80%	
Transplantation Services (Covered only at Exclusive Transplant Network facilities)	80%		80%		80%	
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment (Includes Neurodevelopmental Therapy)**	$20*		$25*		$30*	
Mental Health Services and Substance Use Disorder Services						
Outpatient	$20*		$25*		$30*	
Inpatient, Residential and Partial Hospitalization	80%		80%		80%	

Rx plan choice	$2 / $15 / $30 / $60
Select HSA Rx plan	$2 / $10 / $30 / $50

Eligible Flex Plans are denoted with the + symbol
Rx deductibles and copays apply to the in-network annual coinsurance maximum.
Benefits are calculated on a calendar year.

** Deductible waived*
*** Limited to 30 visits combined for physical therapy, speech therapy, massage therapy, pulmonary rehabilitation, cardiac rehabilitation and post-cochlear implant aural therapy per year. Manipulative treatment is limited to 18 visits per year.*

Effective January 1, 2015

Select plans (continued)	Select 1500+ 1500/35/80%		Select 2000+ 2000/35/80%		Select HSA 2000+ 2000/80%	
	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network
Calendar year costs						
Annual Deductible *Family 2X Individual (except for HSA Plan)	$1,500	$3,000	$2,000	$4,000	$2,000	$4,000
Maximum Out-of-Pocket with Deductible *Family 2X Individual	$4,500	$9,000	$5,000	$10,000	$3,000	$6,000
Maximum Policy Benefit per Covered Person (Combined Network/Out-of-Network)	Unlimited		Unlimited		Unlimited	
Out-of-Network Coinsurance	50%		50%		50%	
Preventive Care (Most out-of-network preventive services are not covered)						
Office Visit	100%*		100%*		100%*	
Lab, X-ray and preventive test	80%		80%		80%	
Emergency/Urgent Care						
Ambulance Services	80%		80%		80%	
Emergency Health Services - Outpatient per visit	$200, then 80%*		$200, then 80%*		80%	
Emergency Health Services - Outpatient others	80%		80%		80%	
Professional Care/Diagnostics						
Office Visit	$35*		$35*		80%	
Urgent Care Office Visits	$35*		$35*		80%	
Vision Exams (Limited to one per year from a Network Provider)	$35*		$35*		80%	
Professional Fees Surgical and Medical Services	80%		80%		80%	
Outpatient Surgery, Diagnostic and Therapeutic Services						
Surgery	80%		80%		80%	
Outpatient Diagnostic and Lab	80%		80%		80%	
CT Scans, PET Scans, MRI and Nuclear Medicine	80%		80%		80%	
Outpatient Therapeutic Treatments	80%		80%		80%	
Facility Care						
Hospital - Inpatient Stay	80%		80%		80%	
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services (Limited to 90 days per year)	80%		80%		80%	
Hospice Care	80%		80%		80%	
Additional Benefits						
Acupuncture Services (Limited to 12 visits per year)	$35*		$35*		80%	
Durable Medical Equipment (Subject to frequency limits)	80%		80%		80%	
Hearing Aids	80%		80%		80%	
Home Health Care (Limited to 130 home health care services per year)	80%		80%		80%	
Prosthetic Devices	80%		80%		80%	
Transplantation Services (Covered only at Exclusive Transplant Network facilities)	80%		80%		80%	
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment (Includes Neurodevelopmental Therapy)**	$35*		$35*		80%	
Mental Health Services and Substance Use Disorder Services						
Outpatient	$35*		$35*		80%	
Inpatient, Residential and Partial Hospitalization	80%		80%		80%	

Rx plan choice	$2 / $15 / $30 / $60
Select HSA Rx plan	$2 / $10 / $30 / $50

Eligible Flex Plans are denoted with the + symbol
Rx deductibles and copays apply to the in-network annual coinsurance maximum.
Benefits are calculated on a calendar year.

** Deductible waived*
*** Limited to 30 visits combined for physical therapy, speech therapy, massage therapy, pulmonary rehabilitation, cardiac rehabilitation and post-cochlear implant aural therapy per year. Manipulative treatment is limited to 18 visits per year.*

moda HEALTH

Effective January 1, 2015

Equity plans	Equity 1000 1000/30/70%		Equity 2000 2000/35/70%		Equity 3000 3000/40/70%		Equity 5000 5000/0/70%		Equity HSA 4000+ 4000/70%	
	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network
Calendar year costs										
Annual Deductible *Family 2X Individual (except for HSA Plan)	$1,000	$2,000	$2,000	$4,000	$3,000	$6,000	$5,000	$10,000	$4,000	$8,000
Maximum Out-of-Pocket with Deductible *Family 2X Individual	$5,000	$10,000	$6,000	$12,000	$6,350	$14,000	$6,350	$18,000	$5,000	$10,000
Maximum Policy Benefit per Covered Person (Combined Network/Out-of-Network)	Unlimited		Unlimited		Unlimited		Unlimited		Unlimited	
Out-of-Network Coinsurance	50%		50%		50%		50%		50%	
Preventive Care (Most out-of-network preventive services are not covered)										
Office Visit	100%*		100%*		100%*		100%*		100%*	
Lab, X-ray and preventive test	70%		70%		70%		70%		70%	
Emergency/Urgent Care										
Ambulance Services	70%		70%		70%		70%		70%	
Emergency Health Services - Outpatient per visit	$200, then 70%*		$200, then 70%*		$200, then 70%*		$200, then 70%*		70%	
Emergency Health Services - Outpatient others	70%		70%		70%		70%		70%	
Professional Care/Diagnostics										
Office Visit	$30*		$35*		$40*		$0*		70%	
Urgent Care Office Visits	$30*		$35*		$40*		$0*		70%	
Vision Exams (Limited to one per year from a Network Provider)	$30*		$35*		$40*		$0*		70%	
Professional Fees Surgical and Medical Services	70%		70%		70%		70%		70%	
Outpatient Surgery, Diagnostic and Therapeutic Services										
Surgery	70%		70%		70%		70%		70%	
Outpatient Diagnostic and Lab	70%		70%		70%		70%		70%	
CT Scans, PET Scans, MRI and Nuclear Medicine	70%		70%		70%		70%		70%	
Outpatient Therapeutic Treatments	70%		70%		70%		70%		70%	
Facility Care										
Hospital - Inpatient Stay	70%		70%		70%		70%		70%	
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services (Limited to 90 days per year)	70%		70%		70%		70%		70%	
Hospice Care	70%		70%		70%		70%		70%	
Additional Benefits										
Acupuncture Services (Limited to 12 visits per year)	$30*		$35*		$40*		$0*		70%	
Durable Medical Equipment (Subject to frequency limits)	70%		70%		70%		70%		70%	
Hearing Aids	70%		70%		70%		70%		70%	
Home Health Care (Limited to 130 home health care services per year)	70%		70%		70%		70%		70%	
Prosthetic Devices	70%		70%		70%		70%		70%	
Transplantation Services (Covered only at Exclusive Transplant Network facilities)	70%		70%		70%		70%		70%	
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment (Includes Neurodevelopmental Therapy)**	$30*		$35*		$40*		$0*		70%	
Mental Health Services and Substance Use Disorder Services										
Outpatient	$30*		$35*		$40*		$0*		70%	
Inpatient, Residential and Partial Hospitalization	70%		70%		70%		70%		70%	

Rx plan choice	$2 / $15 / $30 / $60, $100 deductible
Equity HSA Rx plan	$2 / $10 / $30 / $50

Eligible Flex Plans are denoted with the + symbol
Rx deductibles and copays apply to the in-network annual coinsurance maximum.
Benefits are calculated on a calendar year.

** Deductible waived*
*** Limited to 30 visits combined for physical therapy, speech therapy, massage therapy, pulmonary rehabilitation, cardiac rehabilitation and post-cochlear implant aural therapy per year. Manipulative treatment is limited to 18 visits per year.*

Effective January 1, 2015

Rx plans	Prime Rx 2/10/30/50	Select Rx 2/15/30/60	Equity Rx 100 2/15/30/60	Rx 2/10/30/50 (only available with HSA plans)
Deductible (Individual/family)	N/A	N/A	$100/$300 Combined with Medical	N/A
Value Tier copay	$2	$2	$2	$2
Tier 1 generic copay	$10	$15	$15	$10
Tier 2 preferred copay	$30	$30	$30	$30
Tier 3 brand copay	$50	$60	$60	$50
Mail order (90-day supply)	2.5 X Retail	2.5 X Retail	2.5 X Retail	2.5 X Retail

For cost and further details of the coverage, including exclusions, any reduction or limitations and the terms under which the policy may be continued in force, contact the agent or Moda Health.

This document is provided for informational purposes only, and is intended for licensed and appointed agents of Moda Health. It is not considered a Summary of Benefits and Coverage (SBC), and should not be distributed to employers or their employees as a replacement for the SBC.