Medical Plan Changes for Washington Groups

Effective January 1, 2015

The following is a summary of the significant changes that will be made to the Moda Health Plan, Inc.'s group policy and member handbook effective January 1, 2015. The summary is provided for your convenience and shall not be binding upon the parties. The language in the group policy and member handbook is controlling in all cases. Minor changes, including grammatical, cosmetic, or formatting changes, are not included in this summary.

REGULATORY CHANGES –ACA		
Reference	**Change/Rationale/Exceptions**	**Former Benefit**
Summary of Benefits – Annual Maximum Out-of-Pocket	Maximum in-network out-of-pocket maximums (combining medical and prescription drug expenses): Self – cannot exceed $6,750 Family – cannot exceed $13,500	Maximum in-network out-of-pocket maximums (also applicable to a separate prescription drug out-of-pocket maximum if any): Self – cannot exceed $6,350 Family – cannot exceed $12,700
Summary of Benefits Annual Maximum Out-of-Pocket	Plans must have combined out-of-pocket maximums (self or family) for medical expenses, including prescription drugs, vision (unless vision is deemed excepted benefits, i.e., members can opt out).	For plans without an out-of-pocket maximum for prescription drug expenses in the 2013 plan year opted to continue without prescription drug out-of-pocket maximums for the 2014 plan year
Summary of Benefits – Deductible (HSA compatible plans only)	Minimum in-network deductibles: Self- at least $1,300 Family – at least $2,600 Out-of-network deductibles are 2 times of in-network deductible amounts	Minimum in-network deductibles: Self- at least $1,250 Family – at least $2,500 Out-of-network deductibles are 2 times of in-network deductible amounts

Summary of Benefits – Out-of-Pocket Maximum (HSA compatible plans only)	Maximum in-network out-of-pocket maximums: Self- cannot exceed $6,450 Family – cannot exceed $12,900 Out-of-network out-of-pocket maximums are 2 times of in-network amounts	Maximum in-network out-of-pocket maximums: Self- cannot exceed $6,350 Family – cannot exceed $12,700 Out-of-network out-of-pocket maximums are 2 times of in-network amounts
General Employer Shared Responsibility (Employer Mandate)	Application of the employer shared responsibility penalties becomes effective for groups 100+ in the 2015 plan year	Not effective
OTHER FEDERAL REGULATORY CHANGES		
Reference	**Change/Rationale/Exceptions**	**Former Benefit**
Coordination of Benefits Medicare Secondary Payer Rule	The large group plan pays primary for same sex spouses who have Medicare through age-based entitlement	Same sex spouses are not recognized in the Medicare Secondary Payer Rule
OTHER WASHINGTON STATE REGULATORY CHANGES		
Reference	**Change/Rationale/Exceptions**	**Former Benefit**
Benefit Description Medical Foods	Coverage for medically necessary elemental formula, regardless of delivery method, for members diagnosed with esoinophilic gastrointestinal associated disorders is added. HB 2153	Coverage for nonprescription formulas for treating Phenylketonuria (PKU).
OTHER BENEFIT CHANGES		
Reference	**Change/Rationale/Exceptions**	**Former Benefit**
Summary of Benefits – Ambulance transportation	Under Other Services Classification and services for mental health and chemical dependency are subject to standard in-network and out-of-network cost sharing (deductible, out-of-pocket maximum, coinsurance or copay)	Under Emergency Care Classification and services for mental health and chemical dependency are subject to cost sharing level (deductible, out-of-pocket maximum, coinsurance or copay) whether by in-network or out-of-network providers

Summary of Benefits – Urgent Care Office Visit – Prime plans only	Under Professional Services Classification and services for mental health and chemical dependency are subject to standard in-network and out-of-network cost sharing (deductible, out-of-pocket maximum, coinsurance or copay)	Under Emergency Care Classification and services for mental health and chemical dependency are subject to cost sharing level (deductible, out-of-pocket maximum, coinsurance or copay) whether by in-network or out-of-network providers
Summary of Benefits – Value Tier Medications (HSA compatible plans only)	Waive deductible	Deductible applied
Definitions – Maximum Plan Allowance	MPA for end-stage renal disease (ESRD) facilities during the first 3 months of treatment is the contracted amount for in-network facilities and is based on a supplemental facility fee arrangement for out-of-network facilities. After the first 3 months, MPA is 125% of the Medicare allowable amount for both in-network and out-of-network ESRD facilities.	MPA for end-stage renal disease (ESRD) based on lesser of supplemental facility or provider fee arrangements Moda Health has in place, 125% of the Medicare allowable amount based on date collected from CMS, or the billed charge.
Definitions – Maximum Plan Allowance	MPA for medical devices, including implanted devices, and for durable medical equipment is the contracted amount, or the lesser of a set percentage of the Medicare allowable amount or the acquisition cost of the device plus 10% if there is no contracted amount.	MPA for medical devices is the contracted amount, or the acquisition cost of the device plus 10% if there is no contracted amount.
Benefit Description Preventive Healthcare	Colorectal cancer screenings include related charges for members age 50 and over age 50 who are high risk for colorectal cancer.	Colorectal cancer screenings include related facility and anesthesia charges for members age 50 and over age 50 who are high risk for colorectal cancer.
Benefit Description Preventive Healthcare	Preventive women's healthcare including pelvic and breast exams, Pap tests and mammograms.	Preventive women's healthcare including pelvic and breast exams, Pap tests and mammograms, when recommended by a professional provider.
Benefit Description Radium, Radioisotopic, X-ray Therapy, and Kidney Dialysis	Members with end-stage renal disease (ESRD) must be enrolled in Medicare Part B in order to receive the best benefit. While the Plan is primary for ESRD, Moda Health will reimburse members for Medicare Part B premiums for a maximum of 30 months.	No benefit difference if enrolled in Medicare Part B or not

Benefit Description Medication Administered by Provider, Infusion Center or Home Infusion	Requirement to use exclusive specialty pharmacy for the expense to be covered	Covered benefits when provided by in-network or out-of-network pharmacies
General Exclusions Out-of-country claims	Scheduled care or care that is not due to an urgent or emergency medical condition outside the United States is excluded	Care outside the United States was covered

ADMINISTRATIVE CHANGES	
Reference	**Change/Rationale/Exceptions**
Summary of Benefits Network Information	Changed ODS Plus Network to Connexus
Throughout book	Removed references of "prescription drugs" and changed to "prescription medications" to align with pharmacy industry terminology
Cost Containment Prior Authorization Requirements	Removed cost containment penalty if a member fails to obtain prior authorization for prescription medications. Clarification that penalty did not apply.
Definitions – Chemical Dependency Outpatient Treatment Program	Removed definition because the term is not mentioned elsewhere in the member handbook.
Definitions – Creditable Coverage	Removed the list of creditable coverage examples and included a reference to the federal code instead.
Definitions – Unregistered Domestic Partners	Removed the list of criteria for unregistered domestic partner and referred to the affidavit domestic partnership instead. Some plans may differ from the Moda Health standard criteria
Definitions Moda Health Behavioral Health	Added definition to clarify what Moda Health Behavioral Health does
Definitions Prior Authorization	Add reference to Exhibit A in the handbook, which is a list of services and medications that need prior authorization, and removed reference to website and customer service to obtain the list.
Definitions Professional Provider	Expanded on list of examples of a professional provider
Benefit Description Dental Care	Moved the explanation of when dental care is covered for medical treatment. It had been stated as an exception in the exclusion section.
Benefit Description Inpatient Rehabilitation	Removed the requirement that rehabilitative services must begin within one year of the onset of the related condition

Benefit Description Residential Mental Health and Chemical Dependency Treatment Programs & Chemical Dependency Detoxification Program	Changed per diem charges to daily charges
Benefit Description Prescription Medication Benefit Exclusions	Clarified products not recognized or designated as FDA-approved drugs are excluded
General Exclusions Services Provided by a Relative	Clarified that the exclusion does not apply to dental providers.
Eligibility Disabled Dependents Over 26	Clarified current process of validating coverage extension for disabled children and the required documentation for validation
Enrollment Open Enrollment	Removed reference to a person who is employed by an employer who offers multiple health benefit plans. Applied when plan had a pre-existing waiting period.
Enrollment Certificates of Creditable Coverage	Removed issuance of certificates of creditable coverage in pursuant to federal guidance
Claims Administration & Payment Appeals	Added continued coverage pending the outcome for appeals regarding termination or reduction of an ongoing course of treatment
Claims Administration & Payment External Review	Clarified which adverse benefit determinations can be submitted for external review and clarified time line for member to submit information to the independent review organization
Claims Administration & Payment Third Party Liability	Revised the section to simplify the legal language
Claims Administration & Payment Medicare	Added paragraph about Moda Health reimbursing member with ESRD for Medicare Part B premiums for 30 months.

Exhibit A – Prior Authorization Guidelines	Updated list and made reference to list of infusion services and injectables that can be found on Moda Health's website.
POLICY CHANGES	
Table of Contents	Added table of content
Eligible Employee	Added that an eligible employee refers to a person who satisfies any orientation period and/or Eligibility Waiting Period.
Modification of Policy	Clarified SBC to be provided at least 60 days prior to the effective date of the accepted modifications
Termination	Added the policy may be terminated if a federal or state law no longer permits the offering of coverage
Guaranteed Renewability	Clarified Moda Health is required to accept enrollment of all eligible employees and that coverage may be terminated Moda Health violates its own policies that have been approved by the insurance commissioner.

Additional changes may be required at any time as a result of new federal rules or regulations; changes to existing ACA rules or regulations or State law; language changes as advised by the Washington Office of the Insurance Commissioner during the filing review. Moda Health will provide written notice of any additional changes including any modification to premium rates or administrative fees, and will administer such changes accordingly.