Health plans for every body

2013 Conversion plans

moda

Washington

modahealth.com

Available through December 31, 2013

Do I qualify for a conversion plan?

If you are an employee or member whose coverage terminated under a group health plan, you may be eligible to enroll in a Moda Health Conversion Plan.

Enjoy life with fewer worries — Moda Health has you covered. Our conversion plans can give you and your dependents health coverage and peace of mind. Your spouse or domestic partner and dependent children are eligible, as long as they were covered as dependents under your previous group plan.

Requirements

Before applying, make sure you meet these requirements:

- You have been covered under a Moda Health group plan and are applying for a conversion plan no later than 31 days after termination of coverage or 31 days after receiving notice of termination of coverage, whichever is later; and
- You are a Washington resident; and
- Your group coverage ended as a result of one of the following:
  - Termination of employment other than for misconduct
  - You were covered as a dependent and the employee was terminated based on misconduct
  - Your legal annulment, dissolution of marriage or domestic partnership, or divorce with the employee
  - The employee's death
  - You no longer meet the description of an eligible child

You are not eligible for a Moda Health Conversion Plan if any of the following apply:

- You remain eligible for prior active group coverage
- You are covered under another group health plan
- You are eligible for Medicare

Dependent enrollment and eligibility

If you want to add eligible dependents to your conversion plan, make sure to include them on your application. They must not be covered by Medicare. If accepted by Moda Health, your dependents will be included in your policy.

Your legal spouse or domestic partner is eligible for coverage. Your children are eligible until their 26th birthday.

Qualifying events

New baby? Just married? Congratulations! You can add dependents in the case of certain qualifying events. Your newborn children are covered for the first 21 days after birth. Adopted children are covered for the first 21 days following the date of the adoption decree. You can extend coverage beyond the first 21 days — just submit payment and a completed application.

You can also get coverage for a newly eligible spouse or domestic partner. Simply submit an application within 31 days of his or her eligibility.

Enrollment and effective date

You must submit a completed and signed application no later than 31 days after the termination of your Moda Health group coverage, or 31 days after you receive notice of termination of coverage, whichever is later. Your new coverage becomes effective on the day following termination of coverage under your prior plan.

Terminations

Under certain circumstances, Moda Health can refuse to renew this policy for a member at the end of any period for which premiums are paid. But Moda Health may only do so:

- If a policyholder no longer meets the residency requirements
- For fraud or intentional material misrepresentation by a member
- For material breach by a member
- If premiums are not paid within the grace period

Loss of coverage for a dependent child

Your dependent child will lose coverage under your Moda Health Conversion Plan on the first of the month following his or her 26th birthday. To continue coverage for the dependent only, your child must apply to Moda Health within 31 days of the termination.

General exclusions

We know how important it is to have the tools and care you need to stay healthy. However, we want you to know about some charges and services that are not covered under your conversion plan. In general, these include:

- Charges you are not legally liable to pay
- Charges over the maximum plan allowance
- Charges in excess of what would have been made in the absence of this health coverage
- Charges in connection with accidental bodily injury or sickness incurred during any work done for wage or profit
- Charges in connection with sickness or injury due to war
- Charges for services, supplies or treatments furnished by or covered under a government plan or law, except Medicaid and services rendered in a hospital owned or managed by the state of Washington or a political sub-unit in the state
- Charges of loss in connection with:
  - Dental care (except under the special dental care provision)
  - Cosmetic surgery, except for reconstructive surgery following a mastectomy or medically necessary treatment for congenital anomalies
  - Hearing aids

This is a summary of general exclusions only. For a complete description of limitations and exclusions, refer to your policy.

Let us be your partner in health

At Moda Health, our goal is to help you get well sooner and live well longer. For more than 55 years, we have served our community throughout the Pacific Northwest.

When you choose from our wide range of health plans, you'll get excellent benefits at affordable rates — and just the right amount of coverage you need. We design our benefits around the best medical research, and we go the extra mile to provide you with one-on-one help when you need it.

We also pride ourselves on delivering extraordinary customer service. You can call our helpful, friendly representatives on the phone, or visit www.modahealth.com for health information you and your providers can trust.

Comprehensive Conversion Plan benefits summary*

Standard PPO Plan ODS-SB-CONV-COMP-WA (9/12)	Member responsibility (amount you pay)	
Service	In-network	Out-of-network
Calender year deductible, per member	$500	$15,000
Calender year essential benefit maximum	$2,000,000	
Preventive services		
Annual women's exam – Pap, pelvic, breast exam and mammogram	No copay[1]	50%
Well-baby care	No copay[1]	50%
Routine physical exams	No copay[1]	50%
Immunizations	No copay[1]	50%
Women's preventive contraceptive required under the Affordable Care Act	No copay[1,2]	50%
Professional services		
Office visits (includes urgent care)	20%	50%
Spinal manipulation and acupuncture (10 combined visits per calendar year)	20%	50%
Facility and ancillary services		
Hospital - Inpatient and outpatient surgery; room, ancillary and physician charges; skilled nursing facility care	20%	50%
Maternity - All prenatal/postnatal office visits and doctor delivery; hospital charges	Not covered	
Mental health treatment - Inpatient, outpatient, residential	20%	50%
Routine diagnostic lab and X-ray services; rehabilitation services; medical supplies and devices; in-hospital care; home healthcare	20%	50%
Specified imaging (MRI, CT, CAT, PET scans)	20%	50%
Emergency services		
Emergency room	20%	
Ambulance ($5,000 maximum per calendar year)	20%	
Other benefits		
Prescription services	Not covered; pharmacy discount card available	
Breastfeeding support, supplies and counseling	No copay[1,2]	50%

[1] *Deductible waived.*
[2] *No cost share when utilizing the most cost effective option. See the Limitations section for more details.*
**This is a benefit summary only. For a complete description of benefits, limitations and exclusions, please refer to your policy.*

Both the Summary of Benefits and Coverage and Uniform Glossary, as required under the Affordable Care Act, are available on our website at www.modahealth.com. Once on the Moda Health website, click on the individual and family health plan link, click on conversion and select the plan you are applying for. Paper copy is available free of charge upon request.

Limitations and exclusions for the Comprehensive Conversion Plan

Exclusion periods

Three-month exclusion period applies to:

- Pre-existing conditions for new members enrolled after the initial effective date, unless the member is under the age of 19.

12 -month exclusion period applies to:

- Transplants

Note: Your plan's exclusion period will be shortened one day for each day you had "creditable coverage" under another health plan, provided you do not have a 90-day lapse (or longer) in coverage immediately prior to your effective date in our plan.

Limitations

- All medical and surgical admissions must be authorized by Moda Health; they are subject to a penalty or denial if not authorized.
- The plan has a calendar year maximum of $2,000,000 on all essential benefits as defined by the Affordable Care Act. In-network and out-of-network benefits for such covered expenses accrue toward the calendar year maximum for each member. Once the maximum is met, coverage for all essential benefits will cease until the next calendar year.
- Inpatient rehabilitation benefits are limited to eight days per calendar year. Outpatient rehabilitation benefits, including physical, occupational, speech and massage therapies, are limited to 15 sessions per calendar year.
- Inpatient acute care benefits are limited to 180 days per calendar year.
- Transplant benefits are limited to an aggregate lifetime maximum benefit of $350,000. (12-month exclusion period applies subject to reductions for creditable coverage.)
- Home health benefits are limited to 130 visits per calendar year.
- Six-month hospice benefits, including a calendar-year maximum of 12 days for inpatient care and 170 hours for respite care.
- Skilled nursing facility benefits are limited to 40 inpatient days per calendar year.
- When a member is covered by more than one health plan, combined benefits for these plans will be provided up to, but not exceeding, the allowable expense for all covered services.
- No cost share for women's preventive contraceptives and breastfeeding supplies will apply when an in-network provider and the most cost-effective options are used.

Exclusions

- Services provided by a member of the patient's immediate family.
- Services or supplies which are not medically necessary
- Services and supplies for reversal of sterilization or infertility.
- Services and supplies for obesity, including complications arising out of such treatment, except as required under the Affordable Care Act
- Surgery to alter the refractive character of the eye
- Dental examinations and treatment, except as specifically listed
- Maternity care
- Prescription medications
- Services or supplies for the treatment of sexual dysfunction or inadequacy, or those related to sex change procedures.
- Experimental or investigational treatment
- Services or supplies available in whole, or in part under any city, county, state, or federal law, except Medicaid
- Charges above those considered the maximum plan allowance
- Services or supplies for which an employer is required by law to provide benefits even if you choose not to accept those benefits
- Instruction programs, including, but not limited to, those to learn to self-administer drugs or nutrition, except as specifically provided for under the outpatient diabetic instruction benefit of this plan
- Appliances or equipment primarily for comfort, convenience, cosmetics, environmental control, or education
- Cosmetic / reconstructive services and supplies except for reconstructive breast services or treatment for congenital anomalies
- Services and supplies associated with orthognathic surgery except when required to treat congenital anomalies
- Chemical dependency treatment

Basic Conversion Plan benefits summary*

Standard PPO Plan ODS-SB-CONV-BASIC-WA (9/12)	Member responsibility (amount you pay)	
Service	In-network	Out-of-network
Calender year deductible, per member	$1,000	$15,000
Calender year essential benefit maximum	$2,000,000	
Preventive services		
Annual women's exam – Pap, pelvic, breast exam and mammogram	No copay[1]	50%
Well-baby care	No copay[1]	50%
Routine physical exams	No copay[1]	50%
Immunizations	No copay[1]	50%
Women's preventive contraceptive required under the Affordable Care Act	No copay[1,2]	50%
Professional services		
Office visits (includes urgent care)	0%	50%
Spinal manipulation and acupuncture (10 combined visits per calendar year)	0%	50%
Facility and ancillary services		
Hospital - Inpatient and outpatient surgery; room, ancillary and physician charges; skilled nursing facility care	0%	50%
Maternity - All prenatal/postnatal office visits and doctor delivery; hospital charges	Not covered	
Mental health treatment - Inpatient, outpatient, residential	0%	50%
Routine diagnostic lab and X-ray services; rehabilitation services; medical supplies and devices; in-hospital care; home healthcare	0%	50%
Specified imaging (MRI, CT, CAT, PET scans)	0%	50%
Emergency services		
Emergency room	0%	
Ambulance ($5,000 maximum per calendar year)	0%	
Other benefits		
Prescription services	Not covered; pharmacy discount card available	
Breastfeeding support, supplies and counseling	No copay[1,2]	50%

[1] *Deductible waived.*
[2] *No cost share when utilizing the most cost effective option. See the Limitations section for more details.*
**This is a benefit summary only. For a complete description of benefits, limitations and exclusions, please refer to your policy.*

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Limitations and exclusions for the Basic Conversion Plan

Exclusion periods

Three-month exclusion period applies to:

- Pre-existing conditions for new members enrolled after the initial effective date, unless the member is under the age of 19.

12 -month exclusion period applies to:

- Transplants

Note: Your plan's exclusion period will be shortened one day for each day you had "creditable coverage" under another health plan, provided you do not have a 90-day lapse (or longer) in coverage immediately prior to your effective date in our plan.

Limitations

- All medical and surgical admissions must be authorized by Moda Health; they are subject to a penalty or denial if not authorized.
- The plan has a calendar year maximum of $2,000,000 on all essential benefits as defined by the Affordable Care Act. In-network and out-of-network benefits for such covered expenses accrue toward the calendar year maximum for each member. Once the maximum is met, coverage for all essential benefits will cease until the next calendar year.
- Inpatient rehabilitation benefits are limited to eight days per calendar year. Outpatient rehabilitation benefits, including physical, occupational, speech and massage therapies, are limited to 15 sessions per calendar year.
- Inpatient acute care benefits are limited to 70 days per calendar year.
- Transplant benefits are limited to an aggregate lifetime maximum benefit of $350,000. (12-month exclusion period applies subject to reductions for creditable coverage.)
- Home health benefits are limited to 130 visits per calendar year.
- Six-month hospice benefits, including a calendar-year maximum of 12 days for inpatient care and 170 hours for respite care.
- Skilled nursing facility benefits are limited to 40 inpatient days per calendar year.
- When a member is covered by more than one health plan, combined benefits for these plans will be provided up to, but not exceeding, the allowable expense for all covered services.
- No cost share for women's preventive contraceptives and breastfeeding supplies will apply when an in-network provider and the most cost-effective options are used.

Exclusions

- Services provided by a member of the patient's immediate family.
- Services or supplies which are not medically necessary
- Services and supplies for reversal of sterilization or infertility.
- Services and supplies for obesity, including complications arising out of such treatment, except as required under the Affordable Care Act
- Surgery to alter the refractive character of the eye
- Dental examinations and treatment, except as specifically listed
- Maternity care
- Prescription medications
- Services or supplies for the treatment of sexual dysfunction or inadequacy, or those related to sex change procedures.
- Experimental or investigational treatment
- Services or supplies available in whole, or in part under any city, county, state, or federal law, except Medicaid
- Charges above those considered the maximum plan allowance
- Services or supplies for which an employer is required by law to provide benefits even if you choose not to accept those benefits
- Instruction programs, including, but not limited to, those to learn to self-administer drugs or nutrition, except as specifically provided for under the outpatient diabetic instruction benefit of this plan
- Appliances or equipment primarily for comfort, convenience, cosmetics, environmental control, or education
- Cosmetic / reconstructive services and supplies except for reconstructive breast services or treatment for congenital anomalies
- Services and supplies associated with orthognathic surgery except when required to treat congenital anomalies
- Chemical dependency treatment

Major Medical Conversion Plan benefits summary*

Standard PPO Plan ODS-SB-CONV-MAJ-WA (9/12)	Member responsibility (amount you pay)	
Service	In-network	Out-of-network
Calender year deductible, per member	$5,000	$15,000
Calender year essential benefit maximum	$2,000,000	
Preventive services		
Annual women's exam – Pap, pelvic, breast exam and mammogram	No copay[1]	50%
Well-baby care	No copay[1]	50%
Routine physical exams	No copay[1]	50%
Immunizations	No copay[1]	50%
Women's preventive contraceptive required under the Affordable Care Act	No copay[1,2]	50%
Professional services		
Office visits (includes urgent care)	25%	50%
Spinal manipulation and acupuncture (10 combined visits per calendar year)	25%	50%
Facility and ancillary services		
Hospital - Inpatient and outpatient surgery; room, ancillary and physician charges; skilled nursing facility care	25%	50%
Maternity - All prenatal/postnatal office visits and doctor delivery; hospital charges	Not covered	
Mental health treatment - Inpatient, outpatient, residential	25%	50%
Routine diagnostic lab and X-ray services; rehabilitation services; medical supplies and devices; in-hospital care; home healthcare	25%	50%
Specified imaging (MRI, CT, CAT, PET scans)	25%	50%
Emergency services		
Emergency room	25%	
Ambulance ($5,000 maximum per calendar year)	25%	
Other benefits		
Prescription services	Not covered; pharmacy discount card available	
Breastfeeding support, supplies and counseling	No copay[1,2]	50%

[1] *Deductible waived.*
[2] *No cost share when utilizing the most cost effective option. See the Limitations section for more details.*
**This is a benefit summary only. For a complete description of benefits, limitations and exclusions, please refer to your policy.*

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Limitations and exclusions for the Major Medical Conversion Plan

Exclusion periods

Three-month exclusion period applies to:

- Pre-existing conditions for new members enrolled after the initial effective date, unless the member is under the age of 19.

12 -month exclusion period applies to:

- Transplants

Note: Your plan's exclusion period will be shortened one day for each day you had "creditable coverage" under another health plan, provided you do not have a 90-day lapse (or longer) in coverage immediately prior to your effective date in our plan.

Limitations

- All medical and surgical admissions must be authorized by Moda Health; they are subject to a penalty or denial if not authorized.
- The plan has a calendar year maximum of $2,000,000 on all essential benefits as defined by the Affordable Care Act. In-network and out-of-network benefits for such covered expenses accrue toward the calendar year maximum for each member. Once the maximum is met, coverage for all essential benefits will cease until the next calendar year.
- Inpatient rehabilitation benefits are limited to eight days per calendar year. Outpatient rehabilitation benefits, including physical, occupational, speech and massage therapies, are limited to 15 sessions per calendar year.
- Inpatient acute care benefits are limited to 120 days per calendar year.
- Transplant benefits are limited to an aggregate lifetime maximum benefit of $350,000. (12-month exclusion period applies subject to reductions for creditable coverage.)
- Home health benefits are limited to 130 visits per calendar year.
- Six-month hospice benefits, including a calendar-year maximum of 12 days for inpatient care and 170 hours for respite care.
- Skilled nursing facility benefits are limited to 40 inpatient days per calendar year.
- When a member is covered by more than one health plan, combined benefits for these plans will be provided up to, but not exceeding, the allowable expense for all covered services.
- No cost share for women's preventive contraceptives and breastfeeding supplies will apply when an in-network provider and the most cost-effective options are used.

Exclusions

- Services provided by a member of the patient's immediate family.
- Services or supplies which are not medically necessary
- Services and supplies for reversal of sterilization or infertility.
- Services and supplies for obesity, including complications arising out of such treatment, except as required under the Affordable Care Act
- Surgery to alter the refractive character of the eye
- Dental examinations and treatment, except as specifically listed
- Maternity care
- Prescription medications
- Services or supplies for the treatment of sexual dysfunction or inadequacy, or those related to sex change procedures.
- Experimental or investigational treatment
- Services or supplies available in whole, or in part under any city, county, state, or federal law, except Medicaid
- Charges above those considered the maximum plan allowance
- Services or supplies for which an employer is required by law to provide benefits even if you choose not to accept those benefits
- Instruction programs, including, but not limited to, those to learn to self-administer drugs or nutrition, except as specifically provided for under the outpatient diabetic instruction benefit of this plan
- Appliances or equipment primarily for comfort, convenience, cosmetics, environmental control, or education
- Cosmetic / reconstructive services and supplies except for reconstructive breast services or treatment for congenital anomalies
- Services and supplies associated with orthognathic surgery except when required to treat congenital anomalies
- Chemical dependency treatment

Find your premium

Determine your rate:

1. Choose your plan. All family members must enroll in the same plan for one policy.
2. Find your rate table by your primary applicant's county of residence.
3. Find the rate for your primary applicant by age and tobacco usage (if used in the past 12 months).
4. Add the rate for your spouse, if applying, also based on age and tobacco usage (if used in the past 12 months).
5. Add the rate for each dependent child enrolling with you. Select the appropriate rate from the dependent child row.
6. Add up the rates for all family members on your application. This will be your total monthly premium.

Rates will change when the family composition changes. The new rate will take effect the following month. Moda Health will renew the rates for conversion plans on a yearly basis, beginning Jan. 1, 2014.

Support when and where you need it

Gain peace of mind with our dedication to controlling costs and improving the value and quality of healthcare. You can turn to our nurses, physicians, pharmacists and support staff for help getting the right care, in the right place, at the right time.

Online support

Quickly and easily find information about your plan. Just log into myModa, your personalized member website, at www.modahealth.com. You can find details about your benefits, search for in-network providers, download forms, use helpful health tools, see prescription information and more.

Questions?

We're here to help! You can reach Moda Health Individual Sales at 866-939-0368. Or, visit us online at www.modahealth.com.

Conversion plan rates for Western Washington counties

Clallam, Clark, Cowlitz, Grays Harbor, Island, Jefferson, King, Kitsap, Lewis, Mason, Pacific, Pierce, San Juan, Skagit, Snohomish, Thurston, Wahkiakum, Whatcom

	Comprehensive		Basic		Major Medical	
Age	Non-tobacco	Tobacco	Non-tobacco	Tobacco	Non-tobacco	Tobacco
0-24	$147	$171	$136	$158	$90	$104
25-29	$165	$192	$153	$178	$101	$117
30-34	$190	$222	$176	$205	$116	$135
35-39	$229	$267	$213	$247	$140	$163
40-44	$269	$313	$249	$290	$164	$191
45-49	$336	$391	$311	$362	$205	$239
50-54	$413	$480	$382	$445	$252	$293
55-59	$481	$559	$445	$518	$294	$342
60-64	$548	$638	$508	$591	$335	$389
Dependent child	$121	$121	$112	$112	$74	$74

Conversion plan rates for Eastern Washington counties

Adams, Asotin, Benton, Chelan, Columbia, Douglas, Ferry, Franklin, Garfield, Grant, Kittitas, Klickitat, Lincoln, Okanogan, Pend Oreille, Skamania, Spokane, Stevens, Walla Walla, Whitman, Yakima

	Comprehensive		Basic		Major Medical	
Age	Non-tobacco	Tobacco	Non-tobacco	Tobacco	Non-tobacco	Tobacco
0-24	$153	$178	$142	$165	$93	$109
25-29	$172	$200	$159	$185	$105	$122
30-34	$198	$230	$183	$213	$121	$141
35-39	$239	$278	$221	$257	$146	$170
40-44	$280	$326	$259	$302	$171	$199
45-49	$350	$407	$324	$377	$213	$248
50-54	$429	$500	$398	$463	$262	$305
55-59	$500	$582	$463	$539	$305	$355
60-64	$570	$663	$528	$614	$348	$405
Dependent child	$126	$126	$117	$117	$77	$77

Rates effective through December 31, 2013

moda HEALTH

For help, contact the Moda Health
Individual Sales department at 866-939-0368.

601 S.W. Second Ave.
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For costs 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 Moda Health.

902959 (3/13) SS-1310-WA