2025

Oregon Group Medical Plan

OEBB
High Deductible Health Plan 6
Group# 100000016
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Health Plans in Oregon provided by Moda Health Plan, Inc.

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SECTION 1. WELCOME TO MODA HEALTH

We are pleased OEBB has chosen Moda Health to administer its preferred provider organization (PPO) high deductible health plan. This handbook will give you important information about the Plan's benefits, limitations and procedures.

You also have access to certain value-added services through Moda Health in addition to the benefits outlined in this handbook, including a weight management program and the Moda Health associated smoking cessation program (see Section 15). Visit the Member Dashboard or contact the Health Navigator team for more information about these additional value-added services.

You receive the better benefits of coordinated care by choosing and using a PCP 360, see section 5.2.

If you have questions, call one of the numbers listed in section 2.1 or use the tools and resources on your member website, Member Dashboard at www.modahealth.com/oebb. You can use it 24 hours a day, 7 days a week to get your plan information whenever it is convenient.

This handbook may be changed or replaced at any time, by OEBB or Moda Health, without your agreement. You can find the most current handbook on your Member Dashboard. All plan provisions are governed by OEBB's benefit plan document with Moda Health and this handbook. This handbook may not contain every plan provision.

We may monitor telephone conversations and email communications you have with us. We will only do this when Moda Health determines there is a legitimate business purpose to do so.

You may call the Health Navigator team at 866-923-0409 or email OEBBQuestions@modahealth.com to request a hardcopy of this handbook free of charge.

This Plan is not a Medicare Supplement plan. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare. You can get this from the Group.

SECTION 2. MEMBER RESOURCES

2.1 CONTACT INFORMATION

Moda Health Website (log in to your **Member Dashboard**)
www.modahealth.com/oebb

Some of the things you can do on your Member Dashboard are:

- Find an in-network provider with Find Care
- Update your PCP 360
- Get medication cost estimates and benefit tiers using our Prescription Price Check tool and formulary
- See if a service or supply you need must be prior authorized first (Referral and Authorization link under Resources)

Medical Health Navigator (Customer Service) Department
866-923-0409
En español 888-786-7461
OEBBQuestions@modahealth.com

Behavioral Health
Benefits and claims 888-474-8538
Help finding an in-network provider or program 833-212-5027

Disease Management and Health Coaching
800-913-4957

Hearing Services Preferred Vendor
TruHearing
866-202-2178

Virtual Care Preferred Vendor
CirrusMD
Modahealth.com/cirrusmd

Pharmacy Customer Service Department
866-923-0411

Appeals Department
601 SW 2nd Ave., Portland, OR 97204
Fax 503-412-4003
OregonExternalReview@modahealth.com

Prior Authorization
800-258-2037

Telecommunications Relay Service for the hearing impaired
711

Moda Health
P.O. Box 40384
Portland, Oregon 97240

2.2 MEMBER ID CARD

After you enroll, we will send you ID (identification) cards that show your group and ID numbers, and your provider network. Show your card each time you receive services, so your provider will know you are a Moda Health member. If you lose your ID card, you can get a new one through your Member Dashboard or by calling the Health Navigator team.

2.3 NETWORKS

Network Information (Section 5) explains how networks work and how to choose a PCP 360 for coordinated care benefits. These are the networks for your Plan.

Medical network
Connexus is the primary network, see section 5.1.1 for additional networks available to members who live outside of the primary service area.

Hearing Services network
TruHearing

Pharmacy network
Navitus

Out-of-Area Networks
Members who live in Alaska: First Health Network
Members who live in all other states: Aetna PPO Network

2.4 CARE COORDINATION

2.4.1 Care Coordination

When you have a complex and/or catastrophic medical situation, our Care Coordinators and Case Managers will work directly with you and your professional providers to coordinate your healthcare needs. Care Coordinators and Case Managers are nurses or behavioral health clinicians. They will coordinate access to a wide range of services spanning all levels of care. Coordinating your care helps you get the right services at the right time.

2.4.2 Disease Management & Health Coaching

If you are living with a chronic disease or medical condition, we want to help you improve your health status, quality of life and productivity. Working with a Health Coach can help you follow the medical care plan your professional provider recommends. Health Coaches provide education and support to help you identify your healthcare goals, self-manage your disease and prevent the development or progression of complications. Contact Disease Management and Health Coaching for more information.

2.4.3 Behavioral Health

Moda Behavioral Health provides specialty services for managing mental health and substance use disorder benefits. We can help you access effective care in the right place and contain costs. Behavioral Health Customer Service can help you find in-network providers and understand your mental health and substance use disorder benefits.

2.5 OTHER RESOURCES

You can find other general information about the Plan in Section 14.

See Section 15 for information about additional services, programs and tools to support your physical, mental and emotional health. These resources are not part of the Plan, and they are not insurance.

SECTION 3. SCHEDULE OF BENEFITS

Look through this section for a quick summary of the Plan's benefits.

You must also read the Benefit Description (Section 7) for more details about any limitations or requirements. Link directly there from the Details column of the table below.

You will find details of the actual benefits in the sections after this summary. You will need to know the conditions, limitations and exclusions of the Plan that are explained there. Prior authorization may be required for some services (see Section 6). Important terms are explained in Section 13.

Cost sharing is the amount you pay. See Section 4 for more information, including an explanation of deductible and out-of-pocket maximum. You must choose and use a PCP 360 to get coordinated care benefits (see section 5.2). If you do not use an in-network provider, you may have to pay any amount that is over the maximum plan allowance.

Benefits accrue on a plan year basis beginning October 1st of each year and ending September 30th of the following year.

	In-Network Coordinated Care Benefits	**In-Network Non-coordinated Benefits**	**Out-of-Network Benefits**
Subscriber Only Coverage			
Plan year deductible	**$1,900**	**$2,000**	**$3,500**
Plan year out-of-pocket maximum	**$7,300**	**$7,650**	**$14,000**
Family Coverage:			
Plan year deductible per family	**$4,000**	**$4,000**	**$7,000**
Plan year out-of-pocket maximum per member	**$7,300**	**$7,650**	**$14,000**
Plan year out-of-pocket maximum per family	**$15,300**	**$15,300**	**$28,000**

Services	Cost Sharing Deductible applies unless noted differently			Section in Handbook & Details
	In-network		Out-of-network	
	Coordinated Care Benefits	Non-coordinated Benefits		
Urgent & Emergency Care				
Ambulance Transportation				Section 7.2.1 In-network deductibles and out-of-pocket maximums apply to ambulance transportation services
Coordinated Care	20% after deductible	N/A	20% after deductible	
Non-coordinated Care	N/A	25% after deductible	25% after deductible	
Emergency Room Facility (includes ancillary services)				Section 7.2.2 In-network deductibles and out-of-pocket maximums apply to emergency room services.
Coordinated Care	20% after deductible	N/A	20% after deductible	
Non-coordinated Care	N/A	25% after deductible	25% after deductible	
ER professional / ancillary services billed separately				
Coordinated Care	20% after deductible	N/A	20% after deductible	
Non-coordinated Care	N/A	25% after deductible	25% after deductible	
Urgent Care Office Visit	15% after deductible	20% after deductible	20% after deductible	Section 7.2.3 In-network deductible and out-of-pocket maximum apply to mental health and substance use disorder services
Preventive Services				
Health Maintenance Testing	No cost sharing	No cost sharing	50% after deductible	Section 7.3 Limited to asthma, chronic obstructive pulmonary disease, congestive heart failure and diabetes

Services	Cost Sharing Deductible applies unless noted differently			Section in Handbook & Details
	In-network		Out-of-network	
	Coordinated Care Benefits	Non-coordinated Benefits		
Services as required under the Affordable Care Act, including:	No cost sharing	No cost sharing	50% after deductible	Section 7.3
Colonoscopy	No cost sharing	No cost sharing	50% after deductible	Section 7.3.1
Contraception	No cost sharing	No cost sharing	Not covered	Section 7.3.3
Hearing Screening	No cost sharing	No cost sharing	50% after deductible	Section 7.3.4
Immunizations	No cost sharing	No cost sharing	50% after deductible	Section 7.3.4
Mammogram	No cost sharing	No cost sharing	50% after deductible	Section 7.3.10 One between the ages of 35 and 39, and one per plan year, age 40+
Preventive X-ray & Lab	No cost sharing	No cost sharing	50% after deductible	Section 7.4.10
Preventive Health Exams	No cost sharing	No cost sharing	50% after deductible	Section 7.3.7 6 visits in first year of life 7 exams from age 1 to 4 One per year, age 5+
Tobacco Cessation Treatment				Section 7.3.9
Consultation	No cost sharing	No cost sharing	20% after deductible	
Supplies			20% after deductible	
Women's Exam & Pap Test	No cost sharing	No cost sharing	50% after deductible	Section 7.3.10 One per year
Vision Screening	No cost sharing	No cost sharing	50% after deductible	Section 7.3.6 Age 3 to 5
Other preventive services, including:				
Cardiovascular Screening	No cost sharing	No cost sharing	50% after deductible	Section 7.4.10
Screening X-ray & Lab				Section 7.4.10
At Quest Labs	0% after deductible	0% after deductible	N/A	
All other providers	20% after deductible	25% after deductible	50% after deductible	

Services	Cost Sharing Deductible applies unless noted differently			Section in Handbook & Details
	In-network		Out-of-network	
	Coordinated Care Benefits	Non-coordinated Benefits		
Obesity Screening	No cost sharing	No cost sharing	50% after deductible	Once per plan year
Prostate Rectal Exam	No cost sharing	No cost sharing	50% after deductible	Section 7.3.8 One per year, age 50+
Prostate Specific Antigen (PSA) Test	No cost sharing	No cost sharing		
Wellness Visit	No cost sharing	No cost sharing	N/A	Section 7.3.10 Age 21+
General Treatment Services				
Acupuncture	20% after deductible	25% after deductible	50% after deductible	Section 7.4.1 12 visits per plan year, limit includes both acupuncture and spinal manipulation
Anticancer Medication	20% after deductible	25% after deductible	50% after deductible	Section 7.4.2
Applied Behavior Analysis	15% after deductible	20% after deductible	50% after deductible	Section 7.4.3
Behavioral Health Services				Section 7.4.4
Detoxification (Detox)	15% after deductible	20% after deductible	50% after deductible	
Office Visits	15% after deductible	20% after deductible		
Intensive Outpatient				
Other Outpatient Services				
Coordinated Specialty Programs	0% after deductible	0% after deductible		
Inpatient				
Mental Health Services	20% after deductible	25% after deductible		
Substance Use Disorder	15% after deductible	20% after deductible		
Partial Hospitalization				
Mental Health Services	20% after deductible	25% after deductible		
Substance Use Disorder	15% after deductible	20% after deductible		

Services	Cost Sharing Deductible applies unless noted differently			Section in Handbook & Details
	In-network		Out-of-network	
	Coordinated Care Benefits	Non-coordinated Benefits		
Residential Treatment Program				
Mental Health Services	20% after deductible	25% after deductible	50% after deductible	
Substance Use Disorder	15% after deductible	20% after deductible		
Biofeedback	15% after deductible	20% after deductible	50% after deductible	Section 7.4.5 10 visits lifetime maximum
Dental Injury	20% after deductible	25% after deductible	50% after deductible	Section 7.4.8
Diabetes Services	20% after deductible	25% after deductible	50% after deductible	Section 7.4.9 Supplies covered under DME and Pharmacy benefits
Diagnostic Procedures, including x-ray and lab				Section 7.4.10
At Quest Labs	0% after deductible	0% after deductible	N/A	
All other providers	20% after deductible	25% after deductible	50% after deductible	
Disease Management for Pain	0% after deductible	0% after deductible	50% after deductible	Section 7.4.11
Durable Medical Equipment (DME) Supplies & Appliances	20% after deductible	25% after deductible	50% after deductible	Section 7.4.12 Limits apply to some DME, supplies, appliances
Oral Appliance	20% after deductible	25% after deductible	50% after deductible	Section 7.6.3 $1,800 reference price per oral appliance
Hearing Aids & Related Services				Section 7.4.14
Exam	15% after deductible	20% after deductible	50% after deductible	Frequency limits apply
Other Services	20% after deductible	25% after deductible	50% after deductible	$4,000 maximum every 4 years for members 26 and older
Home Healthcare	20% after deductible	25% after deductible	50% after deductible	Section 7.4.15 140 visits per year
Hospice				Section 7.4.16
Home Care	0% after deductible	0% after deductible	50% after deductible	When palliative care diagnosis is billed in the primary position
Inpatient Care	0% after deductible	0% after deductible	50% after deductible	

Services	Cost Sharing Deductible applies unless noted differently			Section in Handbook & Details
	In-network		Out-of-network	
	Coordinated Care Benefits	Non-coordinated Benefits		
Respite Care	0% after deductible	0% after deductible	50% after deductible	
Hospital Inpatient Care	20% after deductible	25% after deductible	50% after deductible	Section 7.4.17
Hospital Physician Visits	20% after deductible	25% after deductible	50% after deductible	Section 7.4.18
Infusion Therapy				Section 7.4.20 Requires authorization.
Home Infusion for chemotherapy	20% after deductible	25% after deductible	50% after deductible	Some medications may require use of authorized provider to be eligible for coverage
Home Infusion for all other infusion services	0% after deductible	0% after deductible	50% after deductible	
Outpatient Infusion	20% after deductible	25% after deductible	50% after deductible	Some medications may require use of authorized provider to be eligible for coverage. Outpatient hospital setting not covered for some medications
Kidney Dialysis	20% after deductible	25% after deductible	50% after deductible	Section 0
Naturopathic Services				Section 7.4.24
Naturopathic Office Visits	15% after deductible	20% after deductible	50% after deductible	
Naturopathic Substances	20% after deductible	25% after deductible	50% after deductible	
Nutritional Therapy	20% after deductible	25% after deductible	50% after deductible	Section 7.4.26
Office and Home Visits	15% after deductible	20% after deductible	50% after deductible	Section 7.4.27 See also Virtual Care Visits
Virtual Care Visits				Section 7.4.38
Through CirrusMD	0% after deductible	0% after deductible	N/A	Log on via modahealth.com/cirrusmd
Other Providers	$10 per visit, after deductible	$10 per visit, after deductible	50% after deductible	For primary care office visits only

Services	Cost Sharing Deductible applies unless noted differently			Section in Handbook & Details
	In-network		Out-of-network	
	Coordinated Care Benefits	Non-coordinated Benefits		
Rehabilitation & Habilitation (Physical, occupational and speech therapy)	20% after deductible	25% after deductible	50% after deductible	Section 7.4.30 Rehabilitation and habilitation up to 30 outpatient sessions and 30 inpatient days per year. Up to 60 sessions or days for head or spinal cord injury.
Skilled Nursing Facility Care	20% after deductible	25% after deductible	50% after deductible	Section 7.4.31 60 days per year
Spinal Manipulation	20% after deductible	25% after deductible	50% after deductible	Section 7.4.32 12 visits per plan year, limit includes both acupuncture and spinal manipulation
Surgery and Invasive Diagnostic Procedures	20% after deductible	25% after deductible	50% after deductible	Section 7.4.33
Temporomandibular Joint Syndrome (TMJ)	20% after deductible	25% after deductible	50% after deductible	Section 7.4.34
Therapeutic Injections	20% after deductible	25% after deductible	50% after deductible	Section 7.4.35
Therapeutic Radiology	20% after deductible	25% after deductible	50% after deductible	Section 7.4.36
Transplants				Section 7.4.37 Requires authorization
Center of Excellence facilities	20% after deductible	25% after deductible	N/A	
Other facilities	Not covered		Not covered	
Gastric Bypass (Roux-en-Y) or Gastric Sleeve				Section 7.6.1 Covered for members age 18 and over only Center of Excellence reference price applies (complications of a covered surgery are not subject to reference pricing)
Centers of Excellence	$500, then 20% after deductible	$500, then 25% after deductible	N/A	
All other facilities	Not covered	Not covered	Not covered	
Knee/Hip Replacement	20% after deductible	25% after deductible	50% after deductible	Section 0 Facility reference price applies (complications of a covered surgery are not subject to reference pricing)

Services	Cost Sharing Deductible applies unless noted differently			Section in Handbook & Details
	In-network		Out-of-network	
	Coordinated Care Benefits	Non-coordinated Benefits		
Maternity Services				
Breastfeeding				Section 7.5.2
Support and Counseling	0%	0%	50% after deductible	
Supplies			0%	
Infertility				Section 7.5.8
Diagnosis and Surgery	20% after deductible	20% after deductible	50% after deductible	
Ovulation and Intrauterine Insemination	50% after deductible	50% after deductible	50% after deductible	$15,000 lifetime maximum
Infertility Medications	20% after deductible	20% after deductible	50% after deductible	$10,000 lifetime maximum
Maternity	20% after deductible	25% after deductible	50% after deductible	Section 7.5
Newborn Home Visiting Program	0% after deductible	0% after deductible	Not covered	Section 7.5.5 Visit limits apply
Pharmacy				
Prescription Medication	If you use an out-of-network pharmacy, you must pay any amounts charged above the MPA			Section 7.6
Retail Pharmacy				Up to 31-day supply per prescription $35 max cost share for insulin, no deductible
Value Medication	$4	$4	$4	
Select, Preferred and Non-preferred Medication	20%	25%	25%	High-cost generic and non-preferred brand medications are excluded unless a formulary exception is requested and approved.
Mail Order Pharmacy				90-day supply per prescription Must use Moda-designated mail order pharmacy $105 max cost share for insulin, no deductible

Services	Cost Sharing Deductible applies unless noted differently			Section in Handbook & Details
	In-network		Out-of-network	
	Coordinated Care Benefits	Non-coordinated Benefits		
Value Medication	$8	$8	N/A	
Select, Preferred and Non-preferred Medication	20%	25%	N/A	High-cost generic and non-preferred medications are excluded unless a formulary exception is requested and approved.
90-Day Supply at Participating Retail Pharmacies				90-day supply per prescription available for some medications from participating retail pharmacies.
Value Medication	$12, no deductible	$12, no deductible	N/A	
Select, Preferred and Non-preferred Medication	20%	25%	N/A	High-cost generic and non-preferred medications are excluded unless a formulary exception is requested and approved.
Specialty Pharmacy				31-day supply per prescription for most medications. Prior authorization required. Must use a Moda-designated specialty pharmacy
Generic, Preferred and Non-preferred	20%	25%	N/A	Non-preferred brand medications are excluded unless a formulary exception is requested and approved.

SECTION 4. PAYMENT & COST SHARING

4.1 DEDUCTIBLES

Every year, you must will have to pay some expenses before the Plan starts paying. This is called meeting or satisfying your deductible. The deductible is lower when you use in-network providers. You must pay your entire covered expenses until you have spent the deductible amount, unless the Plan specifically says there is no deductible. Then the Plan begins sharing costs with you. Subscribers with self-only coverage must meet the employee-only deductible. For coverage with 2 or more members, you must meet the entire family deductible before benefits are payable for anyone. In-network and out-of-network services have separate deductibles.

Disallowed charges, some manufacturer discounts and/or copay assistance programs do not count toward your annual deductible.

Your deductible is added up on a plan year basis.

4.2 PLAN YEAR MAXIMUM OUT-OF-POCKET

The Plan helps protect you from very high medical costs. The out-of-pocket maximum is an upper limit on how much you have to pay for covered charges each year. Once you have paid the maximum amount, the Plan will pay 100% of covered services and supplies for the rest of the plan year. If more than one member of your family is covered, the per member maximum out-of-pocket applies only until the total family maximum out-of-pocket is reached, even if no single family member has reached the per member maximum. In-network and out-of-network out-of-pocket maximum amounts add up separately and are not combined.

Out-of-pocket costs are added up on a plan year basis.

Payments made by manufacturer discounts and/or copay assistance programs may not count toward your out-of-pocket maximum.

You will always have to pay the following costs, even after your out-of-pocket maximum is met.

a. Out-of-pocket expenses for bariatric surgery that are not done at a Center of Excellence facility, or out-of-pocket expenses above the Center of Excellence reference price
b. Extra expenses you pay when you use a brand medication when a generic is available.
c. Out-of-pocket expenses for an oral appliance above the $1,800 reference price per appliance
d. Out-of-pocket expenses for a hip or knee replacement above the reference price
e. Fees in excess of maximum plan allowance
f. Services in excess of any maximum
g. Premiums
h. Disallowed charges

4.3 PAYMENT

Moda Health, as administrator of the Plan, pays covered expenses based on the maximum plan allowance (MPA). The MPA is defined in Section 13. You may have to pay some of the charges (cost sharing). What you have to pay depends on the Plan provisions, cost sharing may apply.

Except for cost sharing and Plan benefit limitations, in-network providers agree to look only to Moda Health, if it is responsible for payment, for compensation of covered services provided to members.

4.4 EXTRA-CONTRACTUAL SERVICES

Moda Health works with you and your professional providers to consider effective alternatives to hospitalization and other care to make more efficient use of the Plan's benefits. If we believe a service or supply is medically necessary, cost effective and beneficial for quality of care, we may cover the service or supply even though the Plan does not allow it. This is called an extra-contractual (outside the Plan contract) service.

After case evaluation and analysis by Moda Health, extra-contractual services will be covered when Moda Health, and you and your professional provider, agree. Any of us can end these services by giving notice in writing.

The fact that the Plan has paid benefits for extra contractual services for a member does not obligate it to pay such benefits for any other member, nor does it obligate the Plan to pay benefits for continued or additional extra-contractual services for the same member. Extra-contractual benefits paid under this provision will be included in calculating any benefits, limitations or cost sharing under the Plan.

SECTION 5. NETWORK INFORMATION

When you use an in-network provider, you will receive quality healthcare and will have a higher level of benefits. Members who choose coordinated care will receive the highest level of benefits.

When you are at an in-network facility, your care may be provided by physicians, anesthesiologists, radiologists or other professionals who are not in-network. When you receive services from these out-of-network providers, you may have to pay any amounts charged above the MPA (see section 5.1.2). A provider cannot balance bill you unless permitted by law.

When you choose an out-of-network provider, you will get out-of-network benefits for those services. Emergency services are covered at the in-network benefit level.

5.1 GENERAL NETWORK INFORMATION

5.1.1 Network and Service Area

Your network provides services in your service area. Subscribers who live outside the primary service area must contact the Health Navigator team to be assigned to an out-of-area network, so they can continue to access in-network providers.

Ask your providers (both professional providers and facilities) if they participate with the specific network listed below. Do not ask if the provider accepts Moda. There are many Moda Health networks. A provider may participate in some Moda Health networks, but not in the network for your Plan. Contact the Health Navigator team if you need help finding an in-network provider.

Networks

- Connexus for residents of Oregon, southwest Washington, and Idaho
- First Health for residents of Alaska
- Aetna PPO for residents of all other states
- Pharmacy network is Navitus

All members will use only the Connexus network when seeking care within the Connexus service area to receive the in-network benefit.

For more information about these networks or how to find in-network providers, please contact:

Medical Health Navigator (Customer Service) Department
866-923-0409
Email: OEBBquestions@modahealth.com

Out-of-Area Network
You will be assigned to the out-of-area network if:

a. The subscriber lives outside the Connexus service area
b. You are an enrolled child living in the United States but outside the Connexus service area

If your enrolled child moves outside the service area, you must contact the Health Navigator team and the subscriber's employer to update the address in the myOEBB system.

When you are traveling in the United States but outside the Connexus network service area, you may use the out-of-area network.

5.1.2 Out-of-Network Care

When you choose healthcare providers that are not in-network, your benefits are lower, at the out-of-network level shown in Section 3. You may have to pay all of the charges when you get the treatment, and then file a claim to get your out-of-network benefits. If the provider's charges are more than the maximum plan allowance, you may be balance billed and have to pay those excess charges.

When you are getting care at an in-network facility, ask to have related services (such as diagnostic testing, equipment and devices, telemedicine, anesthesia, surgical assistants) performed by in-network providers. When you are at an in-network facility and are not able to choose the provider, you will have the in-network cost sharing for services by out-of-network providers. The provider cannot balance bill you unless permitted by law.

Special Circumstances

We will pay an out-of-network provider at the in-network benefit level when you need emergency care (section 7.2) or for continuity of care (section 9.3). We may also allow the in-network benefit level in these situations:

a. Transition of care: You are a new member and in the middle of treatment with a provider who is out-of-network with us when your coverage under the Plan starts. We may pay in-network benefits for a limited time, while you complete treatment with your provider or your care is safely transferred to an in-network provider.
b. Network adequacy: You need care and there is not an in-network provider within a reasonable distance who can provide timely, cost-effective services to you.

In-network benefits are not automatic (except for emergency services). You or your provider must ask us to prior authorize in-network benefits (see section 6.1.3. We will review your request, and if the criteria are met, we will pay at the in-network benefit level. You will have to pay any charges that are over the maximum plan allowance.

5.1.3 Care After Normal Office Hours

In-network professional providers have an on-call system so you can reach them 24 hours a day. If you need to talk to your professional provider after normal office hours, call their regular office number.

5.2 COORDINATED CARE AND PCP 360

To receive the better benefits of coordinated care, you must choose and use an in-network PCP 360. A directory of in-network PCP 360s can be found:

- on your Member Dashboard under Find Care contact the Health Navigator team for help.

If you are age 18 or older, you may also choose Teladoc (virtual primary care) as your PCP 360.

Each member may choose a different PCP 360, such as a family or general practitioner, a pediatrician or a women's healthcare provider. Select or change your PCP 360 on your Member Dashboard or by calling the Health Navigator team.

If you do not choose a PCP 360, in-network claims will be paid at the non-coordinated benefit level.

If you did not choose a PCP 360 when you enrolled, you may choose a PCP 360 on your Member Dashboard or by calling the Health Navigator team at a later time. Your new PCP 360 may be effective as early as the first day of the month in which you have made the change. A new PCP 360 may affect the cost sharing for services received earlier that month.

You will receive the better benefits of coordinated care when you use your PCP 360 to coordinate your care. If you stop seeing your PCP 360, you will be moved to the non-coordinated care benefit level. When this happens, you will stop receiving the coordinated care benefits.

If a PCP 360 no longer participates in the network, you will receive notice to choose a new PCP 360. If you do not choose and use a new PCP 360, you will be moved to the non-coordinated care benefit level and will stop receiving the coordinated care benefits.

5.3 USING FIND CARE

Find Care is our online directory of in-network providers. To search for in-network providers, log in to your Member Dashboard account at www.modahealth.com/oebb and click on Find Care.

Search for a specific provider by name, specialty or type of service, or look in a nearby area using ZIP code or city.

5.3.1 PCP 360

Find a PCP 360 provider:

a. Choose the “PCP 360” option under the Type drop down menu
b. Enter ZIP code, Search Radius and Search by provider name

The search will bring up a list of PCP 360s. These providers will have a PCP 360 badge icon next to their contact information.

5.3.2 DME Providers

Find a preferred DME provider for savings on your DME:

a. Choose the “Durable Medical Equipment” option under the Specialty drop down menu
b. Enter ZIP code and Search

The search will bring up a list of preferred DME providers. Preferred DME providers have a ribbon icon next to their network name.

SECTION 6. PRIOR AUTHORIZATION

We use prior authorization to make sure your treatments are safe, that services and medications are used correctly, and that cost effective treatment options are used. When a service requires prior authorization, we evaluate it using evidence based criteria that align with medical literature, best practice clinical guidelines and guidance from the FDA. We will authorize medically necessary services, supplies or medications based on your medical condition. You may be required to use a preferred treatment center or provider for the treatment to be covered. Treatments are covered only when there is medical evidence of need.

When your professional provider suggests a type of service that requires authorization (see section 6.1.1), ask your provider to contact Moda Health for prior authorization before you receive the service. Emergency hospital admissions must be authorized by your provider within 48 hours after you are admitted (or as soon as reasonably possible). We will send a letter to tell the hospital, professional provider and you whether the services are authorized. Prior authorization does not guarantee your services will be covered. When a service is otherwise excluded from benefits, charges will be denied.

6.1 PRIOR AUTHORIZATION REQUIREMENTS

When you use an out-of-network provider, you are responsible for making sure that your provider contacts us for prior authorization. If your services are not authorized in advance, we will not pay any benefits. You will have to pay the full charge. Any amounts that you have to pay because you did not get a prior authorization do not count toward your deductible or out-of-pocket maximum.

In-network providers are responsible for obtaining prior authorization for you. If your in-network providers do not do so, they are expected to write off the full charge of the service.

Prior authorization is not required for an emergency admission.

If your medication was not authorized in advance, we may authorize it retroactively.

6.1.1 Services Requiring Prior Authorization

Many of the following types of services may require prior authorization:

a. Inpatient services and residential programs
b. Outpatient services
c. Rehabilitation (physical, occupational, speech therapy)
d. Diagnostic services, including imaging services
e. Infusion therapy
f. Coordinated specialty programs
g. Disease management for pain
h. Medications

Advanced Imaging and Musculoskeletal Services

Your provider must get a prior authorization for these services. You may also have to use a preferred procedure site. Your provider will need to submit an attestation (i.e., documentation

for medical necessity) for higher acuity care settings when the hospital site is selected, or the prior authorization will be denied for site selection.

A full list of services and supplies that must be prior authorized is on the Moda Health website. We update the list from time to time. Ask your provider to check and see if a service or supply requires authorization. You may find out about your authorizations by contacting the Health Navigator team. For mental health or substance use disorder services, contact Behavioral Health Customer Service.

6.1.2 Prior Authorization Limitations

Prior authorization may limit the services that will be covered. Some limits that may apply are:

a. An authorization is valid for a set period of time. Authorized services you get outside of that time may not be covered
b. The treatment, services or supplies/medications that will be covered may be limited
c. The number, amount or frequency of a service or supply may be limited
d. You may have to get treatment from a preferred treatment center or other certain provider for the service or supply to be covered. For some treatments, travel expenses may be covered.

Any limits or requirements that apply to authorized services will be described in the authorization letter that is sent to you and your provider. If you are working with a Care Coordinator or Case Manager (see section 2.4), they can help you understand how to access your authorized treatment.

6.1.3 Out-of-Network Services

If you cannot find an in-network provider or you need to transition your care to an in-network provider (see special circumstances in section 5.1.2), ask for prior authorization. When we cannot find an in-network provider for you, or while you are changing your care to an in-network provider, we may prior authorize your out-of-network care at the in-network benefit level.

When we authorize use of an out-of-network provider, you must make sure that the provider contacts Moda Health for prior authorization of any services that require it.

6.1.4 Second Opinion

We may ask you to see another provider for an independent review to confirm that non-emergency treatment is medically necessary. When we do this, you will only have to pay your deductible for the second opinion.

If you choose to get a second opinion, this will be paid under your regular medical benefits. You will have to pay any deductible and other cost sharing that applies.

SECTION 7. BENEFIT DESCRIPTION

The Plan covers services and supplies described in this handbook when they are medically necessary to diagnose and/or treat a medical condition, or are preventive services. We explain the benefits and the conditions, limitations and exclusions in the following sections. An explanation of important terms is in Section 1213.

Payment of covered expenses is always limited to the maximum plan allowance. Some benefits have day or dollar limits, which are noted in the Details column in the Schedule of Benefits (Section 3).

Many services must be prior authorized (see section 6.1.1). Sometimes you will have to use a certain provider for the service. If your services are not authorized in advance or you do not use the authorized provider, we will not pay any benefits. You may have to pay the full charge.

7.1 WHEN BENEFITS ARE AVAILABLE

We only pay claims for covered services you get when your coverage is in effect. Coverage is in effect when:

a. You meet the eligibility provisions of the Plan
b. You have applied for coverage and we have enrolled you on the Plan
c. OEBB has paid your premiums on time for the current month

Benefits are only payable after the service or supply has been provided. If a limitation or exclusion applies, benefits will not be paid.

7.2 URGENT & EMERGENCY CARE

Emergency services and urgent care are covered. Emergency services are covered at the in-network benefit level. You are covered for treatment of emergency medical conditions (as defined in Section 13) worldwide. If you believe you have a medical emergency, call 911 or seek care from the nearest appropriate provider.

7.2.1 Ambulance Transportation

Medically necessary ground or air ambulance transport, or secure transport, to the nearest facility that is able to provide the treatment you need is covered. Ambulance providers are usually out-of-network. Out-of-network ground ambulance providers may balance bill you.

Services provided by a stretcher car, wheelchair car or other similar methods are not covered. These services are considered custodial.

7.2.2 Emergency Room Care

Medically necessary emergency room care is covered. The emergency room benefit is for services billed by the facility. This may include supplies, labs, x-rays and other charges. Professional fees such as emergency room physician or radiologist reading an x-ray/lab result that are billed separately are paid under inpatient or outpatient benefits.

All claims for emergency services (as defined in Section 13) will be paid at the in-network benefit level. Even when you use an in-network emergency room, some of the providers working in the emergency room and/or hospital may be out-of-network providers (see section 5.1.2 for more information). At an out-of-network emergency room or emergency provider, you cannot be balance billed unless permitted by law.

Prior authorization is not needed for emergency medical screening exams or treatment to stabilize an emergency medical condition. Let your PCP know as soon as possible about any emergency care that you receive.

If you must be admitted to an out-of-network facility, your treating or attending physician will monitor your condition. When they determine you can be safely transferred to an in-network facility, the Plan will stop paying in-network benefits for care at the out-of-network facility.

The in-network benefit level is not available for out-of-network care that is not emergency medical care, unless otherwise stated. These are some examples of services that are not for treatment of emergency medical conditions:

a. Urgent care or immediate care visits
b. Care of chronic conditions, including diagnostic services
c. Preventive services
d. Elective surgery and/or hospitalization
e. Outpatient office visits and related services for a medical or mental health condition

You should not go to an emergency room for these types of services.

7.2.3 Urgent Care

When you have a minor but urgent medical condition that is not a significant threat to your life or health, immediate short-term medical care at an urgent care facility is covered. You must be actually examined by a professional provider.

Visits at walk-in clinics and immediate care facilities are covered under the office visit benefit (section 7.4.27). Immediate care, express care or walk-in care refers to primary care or specialist care that is on-demand and does not require an appointment. Facilities that provide such on-demand care are not urgent care facilities unless their claim billing includes the CMS place-of-service code that is specific for an urgent care facility.

7.3 PREVENTIVE SERVICES

Under the Affordable Care Act (ACA), certain services are covered at no cost to you when you get the care from an in-network provider (see Section 3 for benefit level when services are provided out-of-network). Coverage limitations are based on reasonable medical management techniques where permitted by the ACA. This means that you may have member cost sharing for some alternatives in the services listed below:

a. Evidenced-based services rated A or B by the United States Preventive Services Taskforce (www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations/) and including women's preventive services as of January 1, 2023
b. Immunizations recommended by the Advisory Committee on Immunization Practices of the Center for Disease Control and Prevention (ACIP) (www.cdc.gov/vaccines/hcp/acip-recs/)

c. Preventive care and screenings recommended by the Health Resources and Services Administration (HRSA) for infants, children and adolescents (downloads.aap.org/AAP/PDF/periodicity_schedule.pdf), and women (www.hrsa.gov/womensguidelines/) and including women's services as of January 1, 2023

If one of these organizations makes a new or updated recommendation, it may be up to one year before the related services are covered at no cost sharing.

The Moda Health website has a list of preventive services covered at no cost sharing as required by the ACA. You may also call the Health Navigator team to find out if a preventive service is on this list. Other preventive services have member cost sharing when not prohibited by federal law.

There are additional preventive healthcare services for which the Plan will waive the deductible and any copayments and cover when performed by an in-network provider and billed with a routine diagnosis. Services billed with a medical diagnosis are paid at the standard benefit level.

Some commonly used preventive services covered by the Plan are:

7.3.1 Cardiovascular Screening

One Electrocardiogram (EKG) and treadmill test when performed in conjunction with a covered periodic health exam.

7.3.2 Colorectal Cancer Screening

The following services, including related charges such as consultations and pre-surgical exams, when recommended by the treating professional provider:

a. Fecal occult blood test (FOBT) or fecal immunochemical test (FIT)
b. Fecal DNA test
c. Double contrast barium enema
d. Routine flexible sigmoidoscopy
e. Routine colonoscopy, including polyp removal

Laboratory tests are covered at the medical benefit level. Colorectal cancer screening is covered at the medical benefit if it is not performed for preventive purposes (e.g., screening for diagnostic reasons or to check symptoms). If you have a positive result on a fecal occult blood test covered under the preventive benefit, a follow-up colonoscopy will be covered under the preventive benefit as part of the screening procedure.

General anesthesia is covered at the benefit level of the related colorectal cancer screening if medically necessary. Otherwise is not covered

7.3.3 Contraception

All FDA approved contraceptive methods, including sterilization, and counseling are covered. When you use an in-network provider and the most cost effective option (e.g., generic instead of brand name), you will not have to pay for contraception. If there is not an in-network provider within a reasonable distance who can provide timely, cost-effective contraceptive services to you, ask the Health Navigator team for help. We may prior authorize services at no cost sharing with an out-of-network provider. If your provider determines the cost effective contraception is medically inadvisable for you, we will cover an alternative that they prescribe. Over the counter contraceptives are covered under the Pharmacy benefit (section 7.6). Contraceptives do not need

to be prior authorized and you do not have to try step therapy. Surgery to reverse a vasectomy or tubal ligation is not covered.

7.3.4 Hearing Evaluation

Hearing evaluations when performed in conjunction with a covered well-child examination. Hearing evaluations for adults when performed in conjunction with an adult preventive health exam.

7.3.5 Immunizations

Routine immunizations may be limited to those recommended by vaccine advisory groups such as the West Coast Health Alliance or ACIP. Immunizations only for travel or to prevent illness that may be caused by your work environment are not covered, except as required under the Affordable Care Act.

7.3.6 Pediatric Screenings

Including:

a. Screening for hearing loss in newborn infants.
b. Routine vision screening to detect amblyopia, strabismus and defects in visual sharpness in children age 3 to 5
c. Developmental and behavioral health screenings

7.3.7 Preventive Health Exams

Covered according to the following schedule:

a. Newborn: One hospital visit
b. Infants: 6 well-baby visits during the first year of life
c. Age 1 to 4: 7 exams
d. Age 5 and older: One exam every plan year

A preventive exam is a scheduled medical evaluation that focuses on preventive care and is not problem focused. It includes appropriate history, physical examination, review of risk factors with plans to reduce them, and ordering of appropriate immunizations, screening laboratory tests and other diagnostic procedures.

You will have to pay the standard cost sharing for routine diagnostic x-ray and lab work related to a preventive health exam that is not required by the ACA.

7.3.8 Routine Prostate Rectal Exam & Prostate Specific Antigen (PSA) Test

If you are age 50 or over, the Plan covers one rectal exam and one PSA test is covered every year or as determined by the treating professional provider. If you are at high risk for prostate cancer, as determined by your healthcare provider, prostate rectal exam and PSA test are covered earlier or more often if your professional provider recommends it.

7.3.9 Tobacco Cessation

Covered expenses include counseling, office visits, medications and medical supplies provided or recommended by a tobacco cessation program or other professional provider.

A tobacco cessation program can provide an overall treatment program that follows the United States Public Health Service guidelines for tobacco use cessation. You may have more success with a coordinated program. Look for our partner tobacco cessation program on your Member Dashboard or contact the Health Navigator team.

7.3.10 Wellness Visit
A wellness visit applies to members who are age 21 and older, and shall include a comprehensive medical evaluation including an age and gender appropriate history, family medical history, examination, counseling, anticipatory guidance, and risk factor reduction intervention. The medical evaluation may include assessment of and counseling for BMI, nutrition and diet, activity and blood pressure.

7.3.11 Women's Healthcare
Preventive women's healthcare visits, including one pelvic and breast exam and one Pap test each plan year. Breast exams are limited to women 18 years of age and older. Mammograms are limited to one between the ages of 35 and 39, and one per plan year age 40 and older.

Pap tests, and breast exams, and imaging for screening or diagnosis if you have symptoms or are high risk are also covered when your professional provider decides it is necessary. Pap tests are covered under the office visit or lab test benefit level if they are not within the Plan's age and frequency limits for preventive screening.

Preventive screening, genetic counseling and genetic testing for breast cancer (BRCA) is covered with no cost sharing. Prior authorization is required for genetic testing.

7.4 GENERAL TREATMENT SERVICES

All services must be medically necessary. Many outpatient services must be prior authorized. Some services may need a separate prior authorization. If your doctor does not get the required prior authorization, the charges will not be covered. You may have to pay the full cost. See section 6.1.1 for more information about prior authorization.

7.4.1 Acupuncture
Benefits are limited to a plan year visit limit, which includes spinal manipulation services. Other services you may get at an acupuncture visit, such as office visits or lab and diagnostic services are not covered under this benefit. They are paid under the Plan's standard benefit for the type of service.

7.4.2 Anticancer Medication
Prescribed anticancer medications, including oral, intravenous (IV) or injected medications, are covered. Most anticancer medications need to be prior authorized and have specific benefit limitations. You must get specialty anticancer medications from our designated specialty pharmacy (see section 7.7.6). For some anticancer medications, you may have to enroll in programs to help make sure the medication is used correctly and/or lower the cost of the medication. You can find more information on your Member Dashboard or by contacting the Health Navigator team.

7.4.3 Applied Behavior Analysis (ABA)
Applied behavior analysis (ABA) is a type of treatment for individuals with autism spectrum disorder. ABA is a variety of psychosocial interventions that use behavioral principles to shape behavior. It includes direct observation, measurement and functional analysis of the relationship between environment and behavior. Goals include improving daily living skills, decreasing harmful behavior, improving social functioning and play skills, improving communication skills

and developing skills that result in greater independence. ABA for autism spectrum disorder is covered. Services must be prior authorized.

Examples of what we do not cover:

a. Services provided by your family or household members
b. Custodial or respite care, equine assisted therapy, creative arts therapy, wilderness or adventure camps, music therapy, neurofeedback, chelation or hyperbaric chamber
c. Services provided under an individual education plan (IEP) to comply with the Individuals with Disabilities Education Act
d. Services provided by the Department of Human Services or Oregon Health Authority, other than employee benefit plans offered by the Department and the Authority

7.4.4 Behavioral Health

Behavioral health conditions are mental health and substance use disorders covered by the diagnostic categories listed in the most current edition of the International Classification of Disease or Diagnostic and Statistical Manual of Mental Disorders.

Intensive outpatient mental health treatment and TMS (transcranial magnetic stimulation) must be prior authorized. Coordinated specialty programs must be prior authorized or authorized as soon as reasonably possible after you start them. See section 7.4.10 for coverage of diagnostic services.

Intensive outpatient services are more intensive than routine outpatient and less intensive than a partial hospital program.

a. Mental health intensive outpatient is 3 or more hours per week of direct treatment
b. Substance use disorder intensive outpatient is 9-19 hours per week for adults or 6-19 hours per week for adolescents

A partial hospital program is an appropriately licensed behavioral health facility providing no less than 4 hours of direct, structured treatment services per day. Substance use disorder programs provide 20 or more hours of direct treatment per week. Partial hospital programs do not provide overnight 24-hour care.

A residential program is a state-licensed program or facility providing an organized full-day or part-day program of treatment. Residential programs provide overnight 24-hour care and include programs to treat behavioral health conditions. Residential program does not include any program that provides less than 4 hours per day of direct treatment services.

Mental Health

These services by a mental health provider are covered:

a. Behavioral health assessment
b. Office or home visits, including psychotherapy
c. Intensive outpatient program
d. Case management, skills training, wrap-around services and crisis intervention
e. Coordinated specialty program
f. TMS and electroconvulsive therapy
g. Partial hospitalization, inpatient and residential mental health care

Coordinated Specialty Programs
Mental health care as part of a coordinated specialty program is covered. These programs provide multidisciplinary, team-based care to you and your family. Treatment must be authorized. When you do not have time to get prior authorization, your provider should tell us as soon as possible after you have been admitted.

Coordinated specialty programs are:

a. Crisis and Transition Services (CATS) programs operating under contract with the Oregon Health Authority
b. Early Assessment and Support Alliance (EASA) and Assertive Community Treatment (ACT) provided by Community Mental Health Programs
c. Intensive Outpatient Services and Supports (IOSS)
d. Intensive In-Home Behavioral Health Treatment (IBHT)

Programs must operate under a Certificate of Approval from the Oregon Health Authority to qualify.

Substance Use Disorder Services
Substance use disorder is an addictive physical and/or psychological relationship with any drug or alcohol that interferes on a recurring basis with main life areas such as employment, and psychological, physical and social functioning. Substance use disorder does not mean an addiction to or dependency upon foods, tobacco or tobacco products. Services to assess and treat substance use disorder are covered, including:

a. Outpatient treatment programs. These are state-licensed programs that provide an organized outpatient course of treatment, with services by appointment
b. Room and treatment services for substance use detoxification by a state-licensed treatment program

7.4.5 Biofeedback
Biofeedback therapy services are only covered to treat tension or migraine headaches. There is a lifetime limit to how many visits we will cover.

7.4.6 Child Abuse Medical Assessment
Child abuse medical assessment provided by a community assessment center that reports to the Child Abuse Multidisciplinary Intervention Program is covered. Child abuse medical assessment includes a physical exam, forensic interview and mental health treatment.

7.4.7 Clinical Trials
If you are enrolled in or participating in an approved clinical trial, usual care costs are covered. Usual care costs are medically necessary conventional care, items or services that are covered by the Plan if you get them outside of a clinical trial. The cost sharing will be the same as if the care was not part of a clinical trial.

The Plan does not cover items or services:

a. That are not covered by the Plan if you get them outside of the clinical trial. This includes the drug, device or service being tested, even if it is covered in a different use outside of the clinical trial
b. Required only to provide or appropriately monitor the drug, device or service being tested in the clinical trial

c. Provided only for data collection and analysis needs and that are not used for your direct medical care
d. Usually provided by a clinical trial sponsor free of charge to anyone participating in the clinical trial

We must prior authorize your participation in a clinical trial. Approved clinical trials are limited to those that are:

a. Funded or supported by a center or cooperative group that is funded by the National Institutes of Health, the Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, the Centers for Medicare and Medicaid Services, the U.S. Department of Energy, the U.S. Department of Defense or the U.S. Department of Veterans Affairs
b. Conducted as an investigational new drug application, an investigational device exemption or a biologics license application to the U.S. Food and Drug Administration
c. Exempt by federal law from the requirement to submit an investigational new drug application to the U.S. Food and Drug Administration

7.4.8 Dental Injury

Dental services are not covered, except to treat accidental injury to your natural teeth. Natural teeth are teeth that grew in your mouth.

To be covered, all of the following must be true:

a. The accidental injury must have been caused by a foreign object or was caused by acute trauma (for example, if your tooth breaks when you bite or chew food, that is not an accidental injury)
b. Diagnosis is made within 6 months of the date you were injured
c. Treatment is completed within 12 months of the date of injury
d. Treatment is medically necessary and you get it from a physician or dentist while you are enrolled in the Plan
e. Treatment is limited to that which will restore your teeth to a functional state

If a member chooses to have tooth implant placement as the restoration choice following a covered dental accident, the benefit is limited to the allowed amount for a crown, bridge, or partial over the implant. Removal of tooth implants or attachments to tooth implants are not covered.

Exceptions to the timelines may be made when medically necessary.

7.4.9 Diabetes Services

Insulin and diabetic supplies including insulin syringes, needles and lancets, test strips, glucometers and continuous glucose monitors are covered under the pharmacy benefit (section 7.6), when you buy them from a pharmacy with a valid prescription and using a preferred manufacturer (see the preferred drug list on your Member Dashboard). Insulin pumps may be covered under the DME benefit (section 7.4.12) if you do not get them from a pharmacy.

Examples of covered medical services to screen and manage your diabetes include:

a. HbA1c lab test
b. Checking for kidney disease
c. Annual dilated eye exam or retinal imaging, including one by an optometrist or ophthalmologist

d. Diabetes self-management programs
    i. One diabetes assessment and training program after you are diagnosed with diabetes
    ii. Up to 3 hours of assessment and training following a change of your condition, medication or treatment, when you get it from a program or provider with expertise in diabetes
e. Dietary or nutritional therapy
f. Routine foot care (see section 7.4.28)

7.4.10 Diagnostic Procedures

Services must be for treatment of a medical or mental health condition. Diagnostic services include:

a. X-rays and laboratory tests
b. Standard and advanced imaging procedures
c. Psychological and neuropsychological testing
d. Other diagnostic procedures

If you receive tests through Quest Labs, you will not need to pay any coinsurance after the deductible is met.

Your provider must get prior authorization for most advanced imaging services (see Section 6). This includes radiology (such as MR procedures like MRI and MRA, CT, PET and nuclear medicine) and cardiac imaging. A full list of diagnostic procedures that must be prior authorized is available on the Moda Health website or you may ask the Health Navigator team.

7.4.11 Disease Management for Pain

Structured disease management programs for pain are covered. These programs use a holistic, organized course of treatment to help you manage chronic pain. They incorporate assessment, education, movement therapy and mindfulness training to change your experience of pain and help you improve your functioning. The program must be directed and overseen by a qualified provider. Prior authorization is required. Your provider must get prior authorization.

7.4.12 Durable Medical Equipment (DME), Supplies & Appliances

Equipment and related supplies that help you manage a medical condition. DME is typically for home use and is designed for repeated use.

Some examples of covered DME, supplies and appliances are:

a. CPAP for sleep apnea
b. Glasses or contact lenses, only if you have aphakia or keratoconus
c. Hospital beds and accessories
d. Insulin pumps
e. Intraocular lenses within 90 days following cataract surgery
f. Light boxes or light wands only when treatment is not available at a provider's office
g. Orthotics, orthopedic braces, orthopedic shoes to restore or maintain your ability to do day to day activities or perform your job. If you can get the correction or support you need by modifying a mass-produced shoe, then we will only cover the cost of the modification.
h. Oxygen and oxygen supplies
i. Prosthetics
j. Wheelchair or scooter (including maintenance expenses) limited to one per year under age 19 and one every 3 years age 19 and over

Diabetic supplies, other than insulin pumps and related supplies, are only covered when you get them from a pharmacy. You must have a prescription and use a preferred manufacturer (see section 7.6 for coverage under Pharmacy benefit).

The Plan covers the rental charge for DME. For most DME, the rental charge is covered up to the purchase price. You can work with your providers to order your prescribed DME. Contact the Health Navigator team for help finding a DME provider.

We encourage you to use a preferred DME provider. You may save money when you do. You can find a preferred provider using Find Care on your Member Dashboard (see section 5.3.2). Change your recurring prescription or automated billing to a preferred DME provider by contacting your current provider and the preferred DME provider and asking for the change.

All supplies, appliances and DME must be medically necessary. Your provider may have to prior authorize some DME (see Section 6). Replacement or repair is only covered if the appliance, prosthetic, equipment or DME was not abused, was not used beyond its specifications and not used in a way that voids its warranty. If we ask you to, you must authorize anyone supplying your DME to give us information about the equipment order and any other records we need to approve a claim payment.

Exclusions
In addition to the exclusions listed in Section 8, we will not cover the following appliances and equipment, even if they relate to a covered condition:

a. Those used primarily for comfort, convenience, or cosmetic purposes
b. Those used for education or environmental control (examples under Personal Items in Section 8)
c. Therapeutic devices, except for transcutaneous nerve stimulators (TENS unit)
d. Dental appliances and braces
e. Incontinence supplies
f. Supporting devices such as corsets or compression/therapeutic stockings, except when such stockings are medically necessary
g. Testicular prostheses
h. Wigs and toupees

Moda Health is not liable for any claim for damages connected with medical conditions arising out of the use of any DME or due to recalled surgically implanted devices or to complications of such devices covered by manufacturer warranty.

7.4.13 Gender Affirming Treatment

Eligibility for gender affirming medical and surgical treatment is based on World Professionals Association for Transgender Health (WPATH), Standards of Care, Version 8.

Coverage includes, but not limited to:

a. Mental health
b. Hormone therapy (including puberty suppression therapy for adolescents)
c. Pre-surgery office visits
d. Voice and communication training
e. Hair removal for surgical reconstruction or gender-affirmation
f. Surgical procedures including but not limited to:

i. Breast/chest surgery
ii. Gonadectomy (hysterectomy/oophorectomy or orchiectomy)
iii. Reconstruction of the genitalia
iv. Gender affirming facial surgery

The Plan covers expenses for gender-affirming care under the following conditions:

a. The procedure(s) must be performed by a qualified professional provider
b. The professional provider must obtain prior authorization for the surgical procedure
c. The treatment plan must conform to World Professional Association for Transgender Health, Standards of Care, Version 8
    i. Gender affirming facial surgery performed by a provider at a defined network of Center of Excellence facilities. Please note that not all in-network providers are considered part of the Centers of Excellence for this benefit. Members may go to www.modahealth.com/oebb or contact the Health Navigator team to locate a provider at a Center of Excellence facility.
d. Legal expenses related to name change
e. Travel and lodging expenses

Definitions

Center of Excellence is a facility and/or team of professional providers with which Moda Health has contracted and arranged to provide gender affirming facial surgery services. Centers of Excellence follow best practices, and have exceptional skills and expertise in managing patients with a specific condition.

7.4.14 Hearing Services

Hearing tests, hearing aid checks and aided testing are covered twice per year if you are under age 4 and once per year if you are age 4 and older.

We cover these items once every 3 years for members under age 26 and once every 4 years for members age 26 and over:

a. One hearing aid per hearing impaired ear
b. Repairs, servicing or alteration of the hearing aid equipment
c. Warranty
d. Bone conduction sound processors, if necessary for appropriate amplification and prior authorized (the surgery to install the implant is covered at the surgical benefit level) are covered once every 3 years for members under age 26
e. Hearing assistive technology system, if necessary for appropriate amplification and prior authorized is covered once every 3 years if you are under age 19.

We also cover:

a. Ear molds and replacement ear molds 4 times per year if you are under age 8 and once per year if you are age 8 to 25
b. Initial batteries and one box of replacement batteries per year for each hearing aid if you are under age 26

Members age 26 and over have a 4 year hearing aid maximum (section 3).

The hearing aid must be prescribed, fitted and dispensed by an audiologist or hearing aid specialist and referred by a licensed physician. We may cover a new hearing aid sooner if your existing hearing aid cannot be changed to meet your needs and you are under age 19.

To get the highest benefit level for hearing services, call the Hearing Services preferred vendor to choose an in-network audiologist and schedule a hearing exam. The audiologist will help you choose hearing aids from the selection available to our members by the hearing services vendor through an in-network hearing instrument provider. You can also use other in-network and out-of-network providers, but you may pay more.

Cochlear implants are covered when medically necessary and prior authorized. Benefits include programming and reprogramming the implant, and repair or replacement parts when medically necessary and not covered by warranty.

7.4.15 Home Healthcare

If you are homebound, home healthcare services and supplies from a home healthcare agency are covered. Homebound means that you generally cannot leave home because of your condition If you do leave home, it must be infrequent, for short times, and mainly to get medical treatment. A home healthcare agency is a licensed public or private agency that specializes in providing skilled nursing and other therapeutic services, such as physical therapy, in your home.

Home healthcare must be medically necessary and ordered by your treating practitioner or specialist. Visits are intermittent and must be provided by and require the training and skills of one of the following professional providers:

a. Registered or licensed practical nurse (up to 2 visits per day)
b. Physical, occupational, speech, or respiratory therapist (1 visit per day)
c. Licensed social worker (1 visit per day)

Home health visits have a calendar year maximum. Home health aides are not covered. If you are in hospice, your home healthcare, home care services and supplies are covered under sections 7.4.12 and 7.4.16.

7.4.16 Hospice Care

A hospice is a private or public hospice agency or organization approved by Medicare and accredited by a nationally recognized entity such as the Joint Commission.

Medically necessary or palliative care is covered when you are terminally ill and not getting any more treatment to cure your terminal illness. Services must be part of your hospice treatment plan. The hospice treatment plan is a written plan of care established and periodically reviewed by your treating provider or specialist, who must certify in the plan that you are terminally ill. The plan must describe the services and supplies for medically necessary or palliative care the approved hospice will provide.

Hospice Home Care

Covered charges for hospice home care include services by any of the following:

a. Registered or licensed practical nurse
b. Physical, occupational or speech therapist
c. Home health aide
d. Licensed social worker

A home health aide is an employee of an approved hospice who provides intermittent custodial care under the supervision of a registered nurse, physical therapist, occupational therapist or speech therapist.

Hospice Inpatient Care
Short term hospice inpatient services and supplies are covered for a limited number of days.

Respite Care
Respite Care is care for a period of time to give full-time caregivers relief from living with and caring for a member in hospice. It is covered if you need continuous assistance. It must be arranged by your attending professional provider and prior authorized. We cover hospice care for services provided in the most appropriate setting. We may cover the services and charges of a non-professional provider, but you must get our approval first. Providing care to allow a caregiver to return to work does not qualify as respite care.

Exclusions
In addition to exclusions listed in Section 8, we do not cover:

a. Hospice services provided to other than the terminally ill member, including bereavement counseling for family members
b. Services and supplies not included in the hospice treatment plan or not specifically listed as a hospice benefit

7.4.17 Hospital Care

A hospital is a facility, including a hospital owned or operated by the state of Oregon, that is licensed to provide surgical, medical and psychiatric care. Services must be supervised by licensed physicians. There is 24-hour-a-day nursing service by licensed registered nurses. Care in facilities operated by the federal government that are not considered hospitals is covered when benefit payment is required by law.

All inpatient and residential stays must be prior authorized (see Section 6).

Facility care will only be covered when it is medically necessary. Covered expenses for hospital care are:

a. Hospital room
b. Intensive care unit
c. Isolation care to protect you or other patients from spreading illness
d. Facility charges for surgery performed in a hospital outpatient department
e. Other hospital services and supplies when medically necessary for treatment and ordinarily provided by a hospital
f. Take-home prescription drugs are limited to a 3-day supply at the same benefit level as hospitalization

If you have a serious medical condition that makes a dental procedure risky, or if you cannot be safely and effectively treated in a dental office because you are physically or developmentally disabled, general anesthesia services and related facility charges are covered when you get the dental procedure in an outpatient clinic. Services must be prior authorized.

7.4.18 Hospital Visits
This is when you are actually examined by a professional provider in a hospital. Covered expenses include consultations with written reports and second opinion consultations.

7.4.19 Inborn Errors of Metabolism
Inborn errors of metabolism are related to a gene that is missing or abnormal at birth that affects how your body metabolizes proteins, carbohydrates and fats. We cover treatment for inborn errors of metabolism that have medically standard ways to diagnose, treat and monitor them. Covered services include nutritional and medical care such as clinical visits, biochemical analysis and medical foods used to diagnose, monitor and treat such disorders.

7.4.20 Infusion Therapy
We cover the following medically necessary infusion therapy services and supplies:

a. solutions, medications, and pharmaceutical additives
b. pharmacy compounding and dispensing services
c. durable medical equipment (DME) for the infusion therapy
d. ancillary medical supplies
e. nursing services are covered when prior authorized and ordered by a professional
f. collection, analysis and reporting of the results of laboratory testing services needed to monitor your response to therapy

Your provider must get prior authorization for infusion therapy. You may have to use a preferred medication supplier, home infusion provider or provider office infusion for some medications. When we limit authorization to a certain supplier, provider or setting, medications you get from other suppliers or infusion therapy administered at a hospital outpatient facility or other in-network provider may not be covered.

Home infusion therapy must be provided by an accredited home infusion therapy agency. Members receiving treatment, for services other than chemotherapy will have the coinsurance waived. See section 7.7.6 for self-administered infusion therapy. Some services and supplies are not covered if your provider bills them separately. They are considered included in the cost of other billed charges.

Additional information about the Plan's preferred home infusion providers, including a complete list of services and medications that require prior authorization, is available on Member Dashboard or by contacting the Health Navigator team.

7.4.21 Kidney Dialysis
Covered expenses include:

a. Treatment planning
b. Professional services for administration and supervision
c. Treatments, including therapist, facility and equipment charges

7.4.22 Maxillofacial Prosthetic Services
Maxillofacial prosthetic services you need to restore and manage head and facial structures that cannot be replaced with living tissue are covered when you need these services to:

a. Control or eliminate infection or pain
b. Restore facial configuration or functions such as speech, swallowing or chewing

The problem must be because of:

a. Disease
b. Trauma
c. Birth and developmental deformities

Cosmetic procedures to improve on the normal range of conditions are not covered.

7.4.23 Medication Administered by Provider at a Treatment/Infusion Center

A medication that must be given in a professional provider's office or treatment or infusion center or home infusion is usually covered at the same benefit level as supplies and appliances (see Section 3).

Some medications will not be covered unless you use a preferred treatment center. The treatment program may include office visits, testing, a stay at the treatment center and the medication. Sometimes travel expenses may be included. Treatment must be prior authorized (see section 6.1).

See section 7.4.20 for more information about infusion therapy. Self-administered medications are not covered under this benefit (see section 7.7.6). See section 7.6 for pharmacy benefits.

7.4.24 Naturopathic Services

Prescribed office supplies and substances approved by the Board of Naturopathic Examiners and dispensed by a professional provider are covered. Vitamins and minerals are covered when medically necessary for treatment of a medical condition and prescribed and dispensed by a professional provider. This applies whether the vitamin or mineral is oral, injectable or transdermal.

7.4.25 Nonprescription Enteral Formula for Home Use

The Plan covers nonprescription elemental enteral formula that you use at home. The formula must be medically necessary and ordered by a physician to treat severe intestinal malabsorption. It must be your sole source, or an essential source, of nutrition.

7.4.26 Nutritional Therapy

Dietary or nutritional therapy includes:

a. Assessment of your overall nutritional status
b. Individualized diet and nutritional counseling

Preventive nutritional therapy required under the Affordable Care Act is covered at no cost to you:

a. If you have a body mass index (BMI) of 30 kg/m^2 or higher
b. If you are overweight or obese and have cardiovascular disease risk factors
c. For children age 6 years and older who are overweight or obese
d. If you are female and age 40 to 60 with normal or overweight BMI, to maintain weight or limit weight gain

Also see diabetes services (section 7.4.9) and inborn errors of metabolism (section 7.4.19). Nutritional therapy does not include medical foods or nutritional supplements.

7.4.27 Office or Home Visits
A visit means you are examined by a professional provider. Covered expenses include consultations with written reports and second opinion surgery consultations.

7.4.28 Podiatry Services
Covered to diagnose and treat a specific current problem. Routine podiatry services are not covered unless you have a medical condition (such as diabetes) that requires it.

7.4.29 Pre-admission Testing
Pre-admission testing is covered when ordered by your professional provider.

7.4.30 Rehabilitation & Habilitation
Covered rehabilitative and habilitative services are:

a. Physical therapy
b. Occupational therapy
c. Speech therapy
d. Cardiac rehabilitation
e. Pulmonary rehabilitation

These services must be provided by a licensed physical, occupational or speech therapist, physician, chiropractor or other professional provider licensed to provide such services. Services must be:

a. Medically necessary
b. Part of your professional provider's written treatment plan to improve and restore lost function following illness or injury
c. Inpatient services are in a hospital or other inpatient facility that specializes in such care

Rehabilitative and habilitative services have separate plan year limits. The limits do not apply to medically necessary cardiac or pulmonary rehabilitation or services for behavioral health conditions. We may cover more sessions or days if you have an acute head or spinal cord injury. To get these additional benefits, you must meet the criteria and your provider must get prior authorization before you have used all of your initial sessions or visits. A session is one visit. Only one session of each type of outpatient physical, occupational or speech therapy is covered in one day.

Rehabilitation services restore or improve an ability you have lost because of a medical condition. Habilitative services are used to form skills that you never developed due to a medical condition. They are short term. Your condition is expected to improve in a reasonable and generally predictable period of time. Therapy you get to prevent a condition or function from getting worse or to maintain a current level of functioning without documented improvement is maintenance therapy and is not covered. Recreational or educational therapy, educational testing or training, non-medical self-help or training, or animal therapy are not covered.

7.4.31 Skilled Nursing Facility Care
A skilled nursing facility is licensed to provide inpatient care under the supervision of a medical staff or a medical director. It provides rehabilitative services and 24-hour-a-day nursing services by registered nurses. A limited number of days are covered. Covered expenses are limited to the daily service rate for a semi-private hospital room.

Exclusions
These skilled nursing facility charges are not covered:

a. If you were admitted before you were enrolled in the Plan
b. If the care is mainly for cognitive decline or dementia, including Alzheimer's disease
c. Routine nursing care
d. Non-medical self-help or training
e. Personal hygiene or custodial care

7.4.32 Spinal Manipulation

A limited number of visits are covered each plan year, and that limit includes acupuncture services. Other services you may get at a spinal manipulation visit, such as office visits, lab and diagnostic x-rays, or physical therapy are not covered under this benefit. They are paid under the Plan's standard benefit for the type of service.

7.4.33 Surgery

Surgery (operations and cutting procedures), including treating broken bones, dislocations and burns, is covered. Operating rooms and recovery rooms, surgical supplies and other services ordinarily provided by a hospital or surgical center are covered.

The surgery cost sharing also applies to these following services:

a. Primary surgeon
b. Assistant surgeon
c. Anesthesiologist or certified anesthetist
d. Surgical supplies such as sutures and sterile set-ups when surgery is performed in the physician's office

The services listed above are paid at the surgery copayment or coinsurance level.

Eligible surgery performed in a provider's office is covered, subject to the appropriate prior authorization.

Certain surgical procedures are covered only when performed as outpatient surgery. Ask your professional provider if this applies to a surgery you are planning, or ask the Health Navigator team. Outpatient surgery does not require an inpatient admission or a stay of 24 hours or more.

Cosmetic & Reconstructive
Cosmetic surgery is surgery that maintains or changes how you look. It does not improve how your body works. Reconstructive surgery repairs a birth defect or an abnormality caused by trauma, infection, tumor or disease. Reconstructive surgery is usually done to improve how your body works, but may also be used to approximate a normal appearance.

Cosmetic surgery is not covered. All reconstructive procedures, including surgical, dental and orthodontic repair of birth defects, must be medically necessary and prior authorized or benefits will not be paid. Reconstructive surgery that is partially cosmetic may be covered if it is medically necessary. This includes services to treat a covered mental health condition, such as gender dysphoria.

Treatment for complications related to a reconstructive surgery is covered when medically necessary. Treatment for complications related to a cosmetic surgery is not covered, except to stabilize an emergency medical condition.

Surgery for breast enhancement, making breasts match, and replacing breast implants to change the shape or size of your breasts is not covered, except to treat gender dysphoria (see section 7.4.13) or after a mastectomy.

Reconstructive surgery after a medically necessary mastectomy includes:

a. Reconstruction of the breast on which the mastectomy has been performed, including nipple reconstruction, skin grafts and stippling of the nipple and areola
b. Surgery and reconstruction of the other breast to produce a symmetrical appearance
c. Prostheses (implants)
d. Treatment of physical complications of the mastectomy, including lymphedemas
e. Inpatient care related to the mastectomy and post-mastectomy services

7.4.34 Temporomandibular Joint Syndrome (TMJ)

TMJ treatment may be covered when:

a. You have pain
b. You cannot chew properly
c. For severe acute trauma

Surgery and splints to treat TMJ must be prior authorized. Treatment of related dental diseases or injuries is not covered.

7.4.35 Therapeutic Injections

Administrative services for therapeutic injections, such as allergy shots, are covered when you get them in a professional provider's office. When you can get similar results with self-administered medications at home, the administrative services for therapeutic injections by your provider are not covered. Vitamin and mineral injections are not covered unless they are medically necessary to treat a specific medical condition. More information is in sections 7.4.23 and 7.7.6.

7.4.36 Therapeutic Radiology

Covered expenses include:

a. Treatment planning and simulation
b. Professional services for administration and supervision
c. Treatments, including therapist, facility and equipment charges

7.4.37 Transplants

A transplant is a procedure or series of procedures by which:

a. tissue (e.g., solid organ, marrow, stem cells) is removed from the body of one person (donor) and implanted in the body of another person (recipient)
b. tissue is removed from your body and later put back into your body

We cover medically necessary transplants that follow standard medical practice and are not experimental or investigational. Your doctor should get prior authorization as soon as possible after you know you may be a possible transplant candidate. This section’s requirements do not apply to corneal transplants and collecting and/or transfusing blood or blood products (see section 7.4.33).

Benefits for transplants are limited as follows:

a. Transplant procedures must be done at a Center of Excellence. If a Center of Excellence cannot provide the necessary type of transplant, we will prior authorize services at another transplant facility.
b. Donor costs are covered as follows:
    i. If you are the recipient or self-donor, donor costs related to a covered transplant are covered. If the donor is also enrolled in the Plan, expenses resulting from complications and unforeseen effects of the donation are covered.
    ii. If you are the donor and the recipient is not enrolled in the Plan, we will not pay any benefits toward donor costs.
    iii. If the donor is not enrolled in the Plan, expenses that result from complications and unforeseen effects of the donation are not covered.
c. Professional provider transplant services are paid according to the benefits for professional providers.
d. Immunosuppressive drugs you get during a hospital stay are paid as a medical supply. Outpatient oral and self-injectable prescription medications for transplant related services are paid under the Pharmacy Prescription benefit (section 7.6).
e. We will not pay for chemotherapy with autologous or homogenic/allogenic bone marrow transplant for treatment of any type of cancer not approved for coverage.

A center of excellence is a facility and/or team of professionals that we have agreements with to provide transplant services. Centers of excellence follow best practices, and have exceptional skills and expertise in managing patients with a specific condition.

Donor costs are the covered expenses of removing the tissue from the donor's body and preserving or transporting it to the site where the transplant is performed. It includes any other necessary charges directly related to finding and getting the organ.

7.4.38 Virtual Care Visits (Telemedicine)

A virtual care visit is a live, interactive audio and/or video visit with a provider. It includes diagnosis and treatment of chronic or minor medical conditions. Medical information is communicated in real time between you and your provider at different locations using telephone or internet conferencing, or transmission of data from remote monitoring devices.

A virtual care visit is covered if:
a. The covered service can be safely and effectively provided in a virtual care visit
b. The technology used meets all state and federal standards for privacy and security of protected health information

Additional technologies may be covered, and privacy and security requirements waived, during an Oregon state of emergency.

7.5 MATERNITY CARE

Pregnancy care, childbirth and related conditions are covered when you get the care from a professional provider. Midwives are not considered professional providers unless they are licensed or certified.

Maternity services are usually billed as a global charge. This is a lump sum charge for maternity care that includes prenatal care, labor and delivery, and post-delivery care. Some diagnostic

services, such as amniocentesis and fetal stress test, are not part of global maternity services and are reimbursed separately.

If you have a home birth, the only expenses that are covered are the fees billed by a professional provider. Other home birth charges, such as travel and portable hot tubs, are not covered. Supportive services, such as physical, emotional and informational support to you before, during and after birth and during the postpartum period, are not covered expenses except under the newborn home visiting program (section 7.5.5).

7.5.1 Abortion
Abortions are covered at 100% after deductible when performed by an in-network provider.

7.5.2 Breastfeeding Support
Support and counseling to help you breastfeed successfully is covered while you are pregnant and/or breastfeeding. We cover the purchase or rental charge for a breast pump and supplies. The maximum plan allowance (MPA) does apply when you buy the pump from a retail store. Charges for extra ice packs or coolers are not covered. Hospital grade pumps are covered when medically necessary.

7.5.3 Circumcision
Circumcision within 3 months of birth is covered without prior authorization. A circumcision after age 3 months must be medically necessary and prior authorized.

7.5.4 Diagnostic Procedures
Diagnostic services, including laboratory tests and ultrasounds, related to maternity care are covered. Some of these procedures may need to be prior authorized. A full list of services that must be prior authorized is on the Moda Health website, or you may ask the Health Navigator team.

7.5.5 Newborn Home Visiting Program (Family Connects)
This program may not be available in all counties. Parts of this program are available statewide through virtual care visits. You must use a nurse who is a certified home visiting services provider for services to be covered.

Services include:

a. One comprehensive newborn home visit within 2 to 12 weeks of birth
b. A support visit no more than 2 weeks after birth and before the comprehensive visit if your family has immediate needs after the birth
c. Support telephone calls after the comprehensive home visit
d. One or 2 support visits based on the clinical assessment of the comprehensive home visit
e. A follow-up phone call after the last services provided

Support visits may be a home visit or a virtual care visit. This program ends when your baby is 6 months old.

7.5.6 Office, Home or Hospital Visits
A visit means you are actually examined by a professional provider. In addition to pregnancy care and childbirth visits, nurse home visiting services are covered (see section 7.5.5).

7.5.7 Hospital Benefits

Covered hospital maternity care expenses are:

a. Hospital room
b. Facility charges from a covered facility, including a birthing center
c. Nursery care includes one in-nursery well-newborn infant preventive health exam. You will not have to pay anything when your provider is in-network. Additional visits are covered at the hospital visit benefit level. Nursery care is covered under the newborn's own coverage, and is routine while you are in the hospital and receiving maternity benefits.
d. Other hospital services and supplies when medically necessary for treatment and ordinarily provided by a hospital
e. Take-home prescription drugs are limited to a 3-day supply at the same benefit level as for hospitalization

Special Right Upon Childbirth (Newborns' and Mothers' Health Protection Act)

Benefits for any hospital length of stay related to childbirth will not be restricted to less than 48 hours after a normal vaginal delivery or 96 hours after a cesarean section. You may go home earlier if you and the attending professional provider determine together this is a safe decision for you and your baby. You do not need a prior authorization to stay in the hospital up to these limits.

7.5.8 Infertility Services

Infertility services are covered:

a. Diagnosis and treatment
b. Ovulation induction
c. Intrauterine insemination
d. Fertility preservation (removal and preservation of eggs or sperm) if you are diagnosed with cancer

Lifetime dollar maximums apply for related pharmacy benefits and for ovulation induction, intrauterine insemination and fertility preservation services. Visits and diagnostic procedures to diagnose infertility before treatment are covered under the Plan's standard office visit and diagnostic benefits and do not apply to the dollar maximums.

Exclusions:

These infertility services are not covered:

a. reversal of voluntary sterilization
b. in-vitro fertilization and other advanced reproductive services
c. freezing or storage of eggs or sperm (except for fertility preservation before cancer treatment)
d. donor compensation for time and efforts, including services for unenrolled surrogate mothers

Infertility medications are covered under the pharmacy benefit (see section 7.5.8).

7.6 REFERENCE PRICE PROGRAM

In the reference price program, a set price applies to bariatric surgery, knee/hip replacement and oral appliances (Section 3). Moda Health's networks include providers whose charges are at or

below the reference price. If you receive services from a provider who does not meet the reference price, you are responsible for the difference between the provider's charge and the reference price. Any amount above the reference price does not apply towards the plan year maximum out-of-pocket (section 4.2). You can find a list of providers by accessing your Member Dashboard at www.modahealth.com/oebb. If you are unable to locate a provider who meets the reference price, or have concerns about the quality of services received from providers who meet the reference price, contact the Health Navigator team for assistance.

7.6.1 Gastric Bypass (Roux-en-Y) and Gastric Sleeve

Medically necessary bariatric surgery services, limited to the Roux-en-Y gastric bypass or gastric sleeve surgery, are covered for members who meet all of the following requirements:

a. Are 18 years or older
b. Complete all the requirements listed under section 7.6.1.1 below prior to the surgery and no earlier than 6 months after the date coverage began
c. Meet the requirements as listed under section 7.6.1.2

7.6.1.1 Pre-Surgery Eligibility Requirements:

a. Medical and psychological evaluation
b. A weight loss of 5% over 6 months
c. Dietary counseling and evaluation
d. Documented participation in one of the following programs

    i. Minimum of 6 months participation in OEBB Weight Watchers Program or a recognized commercial behavioral weight management program. The treatment program must include hypocaloric diet changes, nutrition education, and physical activity and behavior change strategies
    ii. Minimum 6 months participation in a physician, nurse practitioner, physician assistant, registered dietician or licensed behavioral therapist-supervised weight loss program, with or without obesity pharmacotherapy
    iii. Three or more primary care visits over a minimum of 6 months with a weight management treatment plan in the medical record
    iv. Participation and completion of an 12-week health education weight management program

e. Medical record documentation that none of the previous weight loss efforts have been sustained and sufficient to address the co-existing medical condition(s) and/or comorbid conditions applicable to the patient

7.6.1.2 Surgery Requirements

a. Body mass index (BMI) ≥35 with one or more co-existing conditions that can be life-threatening:
    i. Sleep apnea uncontrolled on Continuous Positive Airway Pressure (CPAP) or inability to use CPAP with an Apnea/Hypopnea Index (AHI) >15 on sleep study or inability to use CPAP with an AHI >5 and documentation of excessive daytime sleepiness, impaired cognition (ability to think clearly), mood disorders or insomnia, hypertension, ischemic heart disease, or history of stroke
    ii. Congestive heart failure (CHF) or cardiomyopathy with a recommendation for

bariatric surgery from a participating physician who is a cardiologist

iii. Obesity hypoventilation with PC02 ≥45 and a recommendation for bariatric surgery from a participating physician who is a pulmonologist
iv. Diabetes mellitus uncontrolled (HbA1c8 persistently above 7.5) with conventional medical therapy that includes insulin together with an insulin sensitizing oral agent i.e. metformin or pioglitazone (or documented intolerance to insulin or insulin sensitizing oral agents) or > 15 pound weight gain within 2 years of starting insulin therapy
v. Severe hypertriglyceridemia (>1000 mg/dl) uncontrolled with conventional medical therapy that includes trial of at least two fibrate medications and therapeutic doses of omega-3 fatty acid (6 grams daily), as well as alcohol avoidance
vi. Hypertension (high blood pressure) with blood pressure >140/90 (130/80 in the presence of diabetes or renal (kidney) disease) documented on two consecutive visits despite use of three antihypertensive medications including a diuretic (increases urination), unless contraindicated
vii. Refractory extremity edema with ulceration documented by a participating physician
viii. End-stage renal disease with difficulty dialyzing documented by a participating physician who is a nephrologist (kidney specialist)
ix. Pseudotumor cerebri documented by a participating physician who is a neurologist

b. BMI ≥40/ m2 with one or more of the above co-morbid conditions and/or have symptomatic degenerative (deteriorating) joint disease of hip, knee or ankle with abnormal x-rays
c. BMI ≥50/m2 (no co-morbid condition required)
d. BMI ≥ 60:
    i. For members with a BMI ≥60 and/or members 60 years of age or higher, surgical risk decisions regarding the appropriateness of surgery will be made individually based on rehabilitation potential and the participating provider's judgment regarding surgical risk and likelihood of benefit
    ii. For members with a BMI between 60 and 70, decisions regarding surgical timing will be made individually based on rehabilitation potential and the participating provider's judgment regarding surgical risk and benefit
    iii. Surgery is not felt to be appropriate for extreme levels of obesity (BMI >70) and non-surgical strategies for weight loss will be recommended

7.6.1.3 Bariatric Surgery Services Limitations:

a. Services in 7.6.1 are for members age 18 and over only
b. Only Roux-en-Y gastric bypass or gastric sleeve surgery will be performed
c. Surgeries will only be performed at a defined network of Centers of Excellence
d. The maximum plan allowance will be either; a facility reference price of $20,000 for hospitals not subject to ORS 243.879, or 200% of the amount paid by Medicare for facilities subject to ORS 243.879. Complications are not subject to reference pricing
e. Members not eligible for bariatric surgery are not eligible for coverage of complications

7.6.1.4 Definitions:

a. **Centers of Excellence** (COE) means a healthcare facility and/or team of professional providers with which Moda Health has contracted and arranged to provide facility services for Roux-en-Y gastric bypass or gastric sleeve surgery. Centers of Excellence have

rigorous standards based on best practices and have exceptional skills and expertise in managing patients with a specific condition.

7.6.1.5 Travel Benefit:

The Plan will reimburse up to $2,600 for qualified travel expenses to a COE. Per diem and milage limitations are based on the federal government allowances from the US General services Administration (GSA). To qualify for reimbursement, a member must:

a. Live more than 120 miles from a Center of Excellence, and
b. Submit receipts for all travel expenses as proof of payment.

Benefit includes:

Trips to COE	Maximum Nights	With Guest
Pre-surgery consultation	1	Yes
Surgery	6	Yes
One post Surgery follow-up*	1	Yes

*Additional post surgery trips will be covered if medically necessary.

7.6.2 Knee/Hip Replacement

A covered knee or hip replacement, including partial replacement and resurfacing, is subject to reference pricing (Section 3). For more information regarding the Reference Price Program for knee/hip replacement, go to www.modahealth.com/oebb/members/act/procedures.shtml

7.6.2.1 Limitations:

a. A facility reference price of $25,000 for facilities not subject to ORS 243.879, or 200% of the amount paid by Medicare for facilities subject to ORS 243.879
b. If a member chooses not to use a reference price based facility, the member will be responsible for charges in excess of the reference price
c. Complications of a covered surgery are not subject to reference pricing

7.6.2.2 Travel Benefit:

The Plan will reimburse up to $2,600 for qualified travel and lodging expenses for the member and one guest. To qualify for lodging reimbursement, the member must live more than 120 miles from the surgery facility. Per diem and mileage limitations are based on the federal government allowances from the US General services Administration (GSA). Receipts for travel expenses must be submitted as proof of payment.

Trips to Reference Price Facility	Maximum Nights	With Guest
Pre-surgery consultation	1	Yes
Surgery	6	Yes
One post Surgery follow-up*	1	Yes

*Additional post surgery follow-up trips may be covered if medically necessary.

7.6.3 Oral appliance

Expenses for an oral appliance are covered up to a per appliance reference price of $1,800 (Section 3). If you have any questions regarding coverage, contact the Health Navigator team.

7.7 PHARMACY PRESCRIPTION BENEFIT

Prescription medications you get when you are admitted to the hospital are covered by the medical plan as part of your inpatient expense. The prescription medications benefit described here does not apply. All medications must be medically necessary to be covered.

7.7.1 Covered Medication Supply

These medications and supplies are covered when they have been prescribed for you:

a. A prescription medication that is medically necessary for treatment of a medical condition
b. Compounded medications that have at least one covered medication as the main ingredient
c. Insulin and diabetic supplies including insulin syringes, needles and lancets, test strips, glucometers and continuous glucose monitors. You must have a prescription and use a preferred manufacturer
d. Certain prescribed preventive medications required under the Affordable Care Act
e. Medications to treat tobacco dependence, including OTC nicotine patches, gum or lozenges. You must have a prescription. If you use an in-network retail pharmacy, they are covered with no cost sharing as required under the Affordable Care Act
f. Contraceptive medications and devices for birth control (section 7.3.3) and for medical conditions covered under the Plan. You can get up to a 3-month supply the first time you use the medication and up to a 12-month supply after that. Ask Customer Service how to get a 12-month supply.
g. Certain immunizations and related administration fees are covered with no cost sharing at in-network retail pharmacies (such as flu, pneumonia and shingles vaccines)

Certain prescription medications and/or quantities of prescription medications may need to be prior authorized (see Section 6). You must get specialty medications from a Moda-designated specialty pharmacy.

Ask Pharmacy Customer Service to help you coordinate your prescription refills, so you can pick them all up at the same time.

7.7.2 Formulary Exception Requests

Requests for formulary exceptions can be made by you or professional provider through Member Dashboard or by asking Customer Service. Formulary exceptions must be based on medical necessity. The prescribing professional provider's contact information must be submitted, as well as information to support the medical necessity, including all of the following:

a. Formulary medications were tried with an adequate dose and duration of therapy
b. Formulary medications were not tolerated or were not effective
c. Formulary or preferred medications would reasonably be expected to cause harm or not produce equivalent results as the requested medication
d. The requested medication therapy is evidence-based and generally accepted medical practice

We will contact the prescribing professional provider to find out how the medication is being used in the member's treatment plan. Standard exception requests are decided within 72 hours. Urgent requests are decided within 24 hours.

7.7.3 90-Day Supply at Participating Retail Pharmacies

You may buy a 90-day supply from participating retail pharmacies at three times the 31-day supply cost sharing. Not all medications are eligible for a 90-day supply. All standard benefit and administrative provisions (such as prior authorization and step therapy) apply. Search for participating pharmacies using your Member Dashboard. Participating pharmacies will say "3 months" under the Days Supply column in their details.

7.7.4 Mail Order Pharmacy

You can choose to fill prescriptions for covered medications through a Moda-designated mail order pharmacy. Get a mail order pharmacy form from your Group, on your Member Dashboard or ask Customer Service.

7.7.5 Specialty Services & Pharmacy

Specialty medications are often used to treat complex chronic health conditions. Your pharmacist and other professional providers will tell you if your prescription must be prior authorized or if you must get it from a Moda-designated specialty pharmacy. Find out about the clinical services and if your medication is a specialty medications on your Member Dashboard or by asking Customer Service.

Most specialty medications must be prior authorized. If you do not buy specialty medications at the Moda-designated specialty pharmacy, the expense will not be covered. Some specialty prescriptions may be limited to less than 30 days. Some medications may be eligible for a 90-day supply. For some specialty medications, you may have to enroll in a program to make sure you know how to use the medication correctly and/or to lower the cost of the medication. Get more information on your Member Dashboard or by asking the Health Navigation team.

7.7.6 Self-Administered Medication

All self-administered medications follow all of the prescription medication requirements of section 7.6. This includes specialty medication requirements (section 7.7.5) when you get a self-administered specialty medication. Self-administered injectable medications are not covered if you get them in a provider's office, clinic or facility.

7.7.7 Step Therapy

When a medication is part of the step therapy program, you must try certain medications (Step 1) before the prescribed Step 2 medication will be covered. When a prescription for a step therapy medication is submitted out of order, meaning you have not first tried the Step 1 medication before submitting a prescription for a Step 2 medication, the prescription will not be covered. When this happens, your provider will need to prescribe the Step 1 medication.

You or your professional provider can ask for a step therapy exception if:

a. The Step 1 medication is ineffective, harmful, or you cannot tolerate it
b. The Step 1 medication is not giving the same result as the requested Step 2 medication

Make the request through your Member Dashboard or by asking Customer Service. Include your professional provider's contact information. Your request must include information to support that it is medically necessary, including one of these:

a. You tried the Step 1 medication using the right dose and for a long enough time, and it did not work for you
b. You were not able to tolerate the Step 1 medication, or it was not effective for you

c. The Step 1 medication is expected to be harmful to you or not give the same results as the medication you are asking for, based on your condition
d. You tried a Step 2 medication for at least 90 days and had a positive outcome. Changing to the Step 1 medication is expected to be harmful or not give the same result.

We will contact your professional provider to find out how the medication is being used in your treatment plan. Step therapy exceptions must be based on medical necessity and generally accepted medical practice. We will make a decision about your exception request within 72 hours – or just 24 hours if your request is urgent. This exception process is not used for a medication or pharmacy charge that is not covered for other reasons, such as generic substitution, plan limitations or exclusions.

7.7.8 Limitations

The following limitations apply:

a. New FDA approved medications will be reviewed. We may have coverage requirements or limits. You or your prescriber can ask for a medical necessity evaluation if we do not cover a newly approved medication during the review period.
b. If you get a brand medication when a generic equivalent is available, you will have to pay the difference in cost between the generic and brand medication. These additional costs do not count toward your out-of-pocket maximum.
c. You may not bypass the Plan's requirements (such as step therapy, prior authorization) by starting treatment with a medication, whether by using free samples or otherwise; before Plan benefits are payable.
d. Some specialty medications may be limited to a 15-day supply.
e. Medications with dosing intervals greater than the Plan's maximum day supply will have an increased copayment to match the day supply.
f. Medications you buy outside the United States and its territories are only covered in emergency and urgent care situations.
g. You may ask to have your medication refilled early if you are going to travel outside of the United States. When we allow an early refill, it is limited to once every 6 months. You cannot get an early refill to extend your medication supply beyond the end of the plan year.
h. If you need an emergency refill of insulin or diabetic supplies, we will cover it no more than 3 times per year. We will only cover the smallest available package or a 30-day supply, whichever is less.

7.7.9 Exclusions

In addition to the exclusions listed in Section 8, these medications and supplies are not covered:

a. **Devices.** Including, but not limited to therapeutic devices and appliances. Information for contraceptive devices is in section 7.7.1 and for other devices in section 7.4.12
b. **Foreign Medication Claims.** Medications you buy from non-U.S. mail order or online pharmacies or U.S. mail or online pharmacies acting as agents of non-U.S. pharmacies
c. **Hair Growth Medications.**
d. **Immunization Agents for Travel.** Except as required under the Affordable Care Act
e. **Institutional Medications.** To be taken by or administered while you are a patient in a hospital, rest home, skilled nursing facility, extended care facility, nursing home or similar institution
f. **Medication Administration.** A charge to administer or inject a medication, except for immunizations or contraceptives at in-network retail pharmacies

g. **Medications Covered Under Another Benefit.** Such as medications covered under home health, medical, etc.
h. **Medications Prescribed by a Relative.** Prescriptions written or ordered by members or their relatives, including a spouse, domestic partner, child, sibling, or parent of a member or their spouse or domestic partner
i. **Non-Covered Condition.** A medication prescribed for reasons other than to treat a covered medical condition
j. **Nutritional Supplements and Medical Foods.**
k. **Off-label Use.** Medications prescribed for or used for non-FDA approved indications, unless Oregon's Health Evidence Review Commission or Pharmacy Therapeutics and Review Committee has approved it
l. **Over the Counter (OTC) Medications** and certain prescription medications that have an OTC option, except for contraceptives or those treating tobacco dependence
m. **Repackaged Medications.**
n. **Replacement Medications and/or Supplies.**
o. **Sexual Disorders.** Except gender identity medications or devices prescribed or used to treat sexual dysfunction
p. **Untimely Dispensing.** Drugs or medicines that are dispensed more than one year after the order of a professional provider
q. **Vitamins and Minerals.** Except as required by law
r. **Weight Loss Medications.**

7.7.10 Definitions

Brand Medications are medications sold under a trademark and protected name.

Formulary is a list of all prescription medications and how they are covered under the pharmacy prescription benefit. Use prescription price check tool on your Member Dashboard to get coverage information, treatment options and price estimates.

Generic Medications are medications that have been found by the Food and Drug Administration (FDA) to be therapeutically equivalent to the brand option and will often save you money. Generic medications must have the same active ingredients as their brand version and be identical in strength, dosage form and the way you take them.

Nonpreferred Tier Medications are excluded medications, unless a formulary exception is requested and approved. These medications are not designated as preferred, have been reviewed by Moda Health and do not have significant therapeutic advantage over their preferred alternative(s). These products are usually not recommended as first line therapy and different methods of treatment exist. See section 7.7.2 for information about making a formulary exception request.

Over the Counter (OTC) Medications are medications that you can buy without a professional provider's prescription. We consider a medication OTC as determined by the FDA.

Prescription Medication List Our Moda Health Prescription Medication List is on your Member Dashboard. It gives you information about how commonly prescribed medications are covered. Not every covered medication is on the list. We will review new medications and may set coverage limitations.

What tier a medication is in may change and will be updated from time to time. Use the prescription price check tool on your Member Dashboard to get the latest information. Ask Customer Service if you have any questions.

Prescribing and dispensing decisions are to be made by your professional provider and pharmacist using their expert judgment. Talk with your professional providers about whether a medication from the list is appropriate for you. This list is not meant to replace your professional provider's judgment when deciding what medication to prescribe to you. Moda Health is not responsible for any prescribing or dispensing decisions.

Preferred Tier Medications are medications, including specialty preferred medications, that we have reviewed and found to be safe and effective at a better price compared to other medications in the same therapeutic class and/or category. Generic medications that have not been shown to be safer or more effective than other more cost effective generic medications are included in this tier. These high cost generic medications are excluded unless a formulary exception is requested and approved. See section 7.7.2 for information about making a formulary exception request.

Prescription Medications include the notice "Caution - Federal law prohibits dispensing without prescription". You must have a prescription from your professional provider to get these medications.

Select Tier Medications are the most cost effective options in their therapeutic category. This tier includes generic and certain brand medications, including specialty medications, that are safe, effective and cost effective.

Self-Administered Medications are labeled by the FDA for self-administration. You or your caregiver can safely administer these medications to you outside of a medical setting (such as a physician's office, infusion center or hospital).

Specialty Medications are often used to treat complex chronic medical conditions. Specialty medications often require special handling and have a unique ordering process. Most specialty medications must be prior authorized.

Value Tier Medications include commonly prescribed medications used to treat chronic medical conditions. They are considered safe, effective and cost-effective compared to other medication options. A list of value tier medications is on your Member Dashboard.

SECTION 8. GENERAL EXCLUSIONS

This section lists Plan exclusions. These are in addition to the limitations and exclusions that are described in other sections. These services, supplies and conditions are not covered, even if they are medically necessary, are recommended or provided by a professional provider, or they relate to a covered condition. Treatment of a complication or consequence that happens because of an exclusion is not covered. Except, treatment of an emergency medical condition is always covered. We do not exclude services solely because an injury results from an act of domestic violence.

Benefits Not Stated
Services and supplies not included in this handbook as covered expenses, unless required under state or federal law

Charges Over the Maximum Plan Allowance
Except when required under the Plan's coordination of benefits rules (see section 9.4.1)

Correctional Services
Including sheltered living provided by a half-way house, education-only court ordered anger management classes, and court ordered sex offender treatment

Cosmetic Procedures
Any procedure or medication with the main purpose of changing or maintaining your appearance and that will not result in significant improvement in body function. Examples include rhinoplasty, breast enhancement, liposuction and hair removal. Reconstructive or gender affirming surgery is covered if medically necessary and not specifically excluded (see section 7.4.33)

Custodial Care
Routine care and hospitalization that helps you with everyday life, such as bathing, dressing, getting in and out of bed, preparing special diets and helping you with medication that usually can be self-administered. Custodial care is care that can be provided by people without medical or paramedical skills.

Dental Examinations and Treatment; Orthodontia
Except services described in sections 7.4.8 and 7.4.22, or if medically necessary to restore function due to craniofacial irregularity

Educational Supplies and Services
Including the following, unless provided as a medically necessary treatment for a covered medical condition:

a. Books, tapes, pamphlets, subscriptions, videos and computer programs (software)
b. Psychoanalysis or psychotherapy as part of a training or educational program, regardless of your diagnosis or symptoms
c. Educational services provided by a school, including a boarding school
d. Level 0.5 education-only programs

Experimental or Investigational Procedures
Expenses due to experimental or investigational procedures. Includes related expenses, even if they would be covered in other (non-experimental, non-investigational) situations (see definition of experimental/investigational in Section 13)

Faith Healing

Food Services
Including Meals on Wheels and similar programs, and guest meals in a hospital or skilled nursing facility

Home Birth or Delivery
Charges other than the professional services billed by your professional provider, including travel, portable hot tubs and transportation of equipment

Illegal Acts
Services and supplies to treat a medical condition caused by or arising directly from your illegal act.

Infertility
Donor compensation for time and efforts, services for unenrolled surrogate mothers and advanced reproductive services for infertility are not covered. Advanced reproductive services include In-vitro Fertilization (IVF), Zygote Intra-Fallopian Transfer (ZIFT), Gamete Intra-Fallopian Transfer (GIFT), Pre-Implantation Genetic Diagnosis (PGD), Intractoplasmic Sperm Injection (ICSI), ovum microsurgery, reversal of voluntary sterilization, and freezing or storage of eggs or sperms when the member does not have a cancer diagnosis. See section 7.5.8 for covered infertility services. Includes surgery to reverse elective sterilization (vasectomy or tubal ligation).

Inmates
Services and supplies you get while you are in the custody of any state or federal law enforcement authorities or while in jail or prison, except when in an Oregon state or local facility and pending disposition of charges (waiting for your case to be resolved). Benefits paid under this exception may be limited to 115% of the Medicare allowable amount. Injuries under the Illegal Acts exclusion are not covered.

Massage or Massage Therapy

Never Events
Services and supplies related to never events. These are events that should never happen when you receive services in a hospital or facility. Examples include the wrong surgery, surgery on the wrong body part or surgery on the wrong patient. These also apply to any hospital acquired condition, as that term is defined in the Centers for Medicare and Medicaid Services (CMS) guidelines, and which includes serious preventable events.

Non-Therapeutic Counseling
Including legal, financial, vocational, spiritual and pastoral counseling

Nuclear Radiation
Any medical condition arising from ionizing radiation, pollution or contamination by radioactivity from any nuclear waste from the combustion of nuclear fuel, and the radioactive, toxic, explosive

or other hazardous properties of any explosive nuclear assembly or component, unless otherwise required by law.

Nutritional Counseling
Except as described in section 7.4.26

Obesity or Weight Reduction
Even if you are morbidly obese. Services and supplies including:

a. Gastric restrictive procedures with or without gastric bypass, (except as provided in section 7.6.1), or the revision of such procedures
b. Weight management services such as weight loss programs, exercise programs, counseling (except as described in section 7.4.26), hypnosis, biofeedback, neurolinguistic programming, guided imagery, relaxation training and subliminal suggestion used to change your eating behavior except for specific programs offered to you including Weight Watchers®
c. Any medication or formula related to or resulting from the treatment of weight loss or obesity even if prescribed by a physician

The Plan covers services and supplies that are necessary to treat established medical conditions that may be caused by or made worse by obesity. Services and supplies that do so by treating the obesity directly are not covered, except as required under the Affordable Care Act and as provided in section 7.6.1.

Orthopedic Shoes
Except as described in section 7.4.12

Orthognathic Surgery
Including associated services and supplies

Personal Items
Including basic home first aid and things that can make you feel better but are not required medical treatment, necessities of living such as food and household supplies, and supportive environmental materials like handrails, humidifiers, filters and other items that are not for treatment of a medical condition even if they relate to a condition that is otherwise covered.

Pharmacies Excluded from the Network
Medications from pharmacies that are not allowed to contract with the network. This includes pharmacies that have been excluded from the network for non-compliance with fraud, waste and abuse laws.

Physical Exercise Programs
Programs, videos and exercise equipment

Private Nursing Services

Professional Athletic Activities
Diagnosis, treatment and rehabilitation services for injuries you get while you are practicing for or participating in a professional or semi-professional athletic contest or event. These are events or activities you are paid or sponsored to do full-time or part-time

Reports and Records
Including charges for completing claim forms or treatment plans

Routine Foot Care
Including the following services unless your medical condition (such as diabetes) requires them:

a. Trimming or cutting of overgrown or thickened lesion (like a corn or callus)
b. Trimming of nails, regardless of condition
c. Removing dead tissue or foreign matter from nails

Self-Administered Medications
Including oral and self-injectable when you get them directly from a physician's office, facility or clinic instead of through the pharmacy prescription medication or anticancer benefits (sections 7.7.6 and 7.4.2)

Self-Improvement Programs
Psychological or lifestyle improvement programs including educational programs, retreats, assertiveness training, marathon group therapy and sensitivity training unless they are a medically necessary treatment for a covered medical condition

Service Related Conditions
Treatment of any condition caused by or arising out of your service in the armed forces of any country or as a military contractor or from an insurrection or war, unless not covered by your military or veterans coverage

Services for Administrative or Qualification Purposes
Physical or mental examinations, psychological testing and evaluations and related services for purposes such as employment or licensing, participating in sports or other activities, insurance coverage, or deciding legal rights, administrative awards or benefits, or corrections or social service placement. The only exception is as specifically described in section 7.4.6

Services Not Provided
Services or supplies you have not actually received. This includes missed appointments

Services Otherwise Available
Someone else should have been responsible for the cost of these services or supplies. Examples include these situations:

a. You have not been charged or the charge has been reduced or discounted, or you would not normally be charged if you do not have insurance
b. Another third party has paid or is obligated to pay, or would have paid if you had applied for the program. This may include coverage provided under a separate contract that provides coordinated coverage and are considered part of the same plan. It could also be a government program (except Medicaid) or a hospital or program operated by a government agency or authority.

This exclusion does not apply to covered services or supplies you get from a hospital owned or operated by the state of Oregon or any state approved community mental health and developmental disabilities program, or the Veterans' Administration of the United States if the care is not service related.

Services Provided or Ordered by a Family Member
Other than services by a dental provider. For the purpose of this exclusion, family members include you and your spouse or domestic partner, your child, your sibling, or your parent, or your spouse's or domestic partner's parent.

Services Provided by Volunteer Workers

Sexual Dysfunction of Organic Origin
Services for sexual dysfunctions of organic origin, including impotence and decreased libido. Except medically necessary mental health services and supplies related to diagnoses listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders.

Support Groups
Including voluntary mutual support groups such as 12-step programs and family education or support groups, except as required under the Affordable Care Act.

Taxes, Fees and Interest
Except as required by law

Telehealth
Except telemedicine as specifically described in section 7.4.38

Therapies
Services or supplies related to animal therapy, and maintenance therapy and programs.

Third Party Liability Claims
Services and supplies to treat a medical condition that a third party is or may be responsible for, to the extent of any recovery received from or on behalf of the third party (see section 9.4.3)

Transportation
Except medically necessary ambulance or secure transport as described in section 7.2.1

Treatment in the Absence of Illness
Including individual or family counseling or treatment for marital, behavioral, financial, family, occupational or religious problems, treatment for at risk individuals who do not have an illness or a diagnosed behavioral health condition, or treatment of normal transitional response to stress

Treatment After Coverage Ends
The only exceptions are:

a. You are hospitalized when the Plan ends and your services continue to meet the criteria for medical necessity (see section 11.8.1)
b. Covered hearing aids ordered before your coverage ends and you get them no more than 90 days after the end date.

Treatment Before Coverage Begins
Including services and supplies for an admission to a hospital, skilled nursing facility or other facility that began before your coverage under the Plan began. We will provide coverage only for those covered expenses incurred on or after your effective date under the Plan.

Treatment Not Medically Necessary
Including services or supplies that do not meet our medical necessity criteria or are:

a. Prescribed for purposes other than preventing or treating physical or mental illness
b. Inappropriate or inconsistent with the symptoms or diagnosis of your condition
c. Not established as the standard treatment by the medical community in the service area where you receive them
d. Primarily for your convenience or that of a provider
e. Not the least costly of the alternative supplies or levels of service that can be safely provided to you

If a service is not medically necessary to treat or diagnose your condition, it is not covered even if the condition is otherwise covered under the Plan. The fact that a professional provider may prescribe, order, recommend or approve a service or supply does not, of itself, make the charge a covered expense.

Vision Care
Including eye exams, the fitting, provision or replacement of eyeglasses or contact lenses, and any charges for orthoptics, vitamin therapy, low vision therapy, eye exercises or fundus photography, except where specifically covered under the Plan. See section 7.4.9 for coverage of annual dilated eye exam to manage diabetes.

Vision Surgery
Any procedure to cure or reduce near-sightedness, far-sightedness or astigmatism. Includes reversals or revisions, and treating any complications of these procedures.

Vitamins and Minerals
Not covered unless required by law or if medically necessary to treat a specific medical condition and prescribed and dispensed by a licensed professional provider under the medical benefit. Applies whether the vitamin or mineral is oral, injectable, or transdermal.

Wigs, Toupees, Hair Transplants

Work Related Conditions
Treatment of a medical condition you get because of your employment or self-employment, unless the expense is denied as not work related under any workers' compensation provision. You must file a claim for workers' compensation benefits and send us a copy of the workers' compensation denial letter to be eligible for payment under the Plan. This exclusion does not apply if you are an owner, partner or executive officer, if you are exempt from workers' compensation laws and the Group does not provide workers' compensation coverage to you.

SECTION 9. CLAIMS ADMINISTRATION & PAYMENT

9.1 SUBMISSION & PAYMENT OF CLAIMS

What to know about sending us a claim:

a. We must receive your claim no more than 12 months after the date of service
b. We do not always pay claims in the same order you received the services. This may affect how your cost sharing is applied to claims. For example, a deductible may not be applied to the first date you were seen in a benefit year if we pay a later date of service first
c. We will not pay any claims we do not receive on time. The only exceptions are Medicaid claims or absence of legal capacity. Claims from Medicaid must be sent to us no more than 3 years after the date of service
d. We may pay benefits to you, to the provider, or both of you

The date of service is the date you receive the service or supply. You must actually receive the service or supply before we will pay the claim.

Usually, you can show your Moda Health ID card to the provider, and they will bill us for you. We will pay the provider and send a copy of our payment record to you. The provider will then bill you for any charges that were not covered.

9.1.1 How to Send Us Claims

Sometimes you will have to pay a provider up front. When you are billed by the hospital or professional provider directly, send us a copy of the bill (see section 2.1).

Include all of the following information:

a. Patient's name, subscriber's name, and group and ID numbers
b. Date of service
c. Diagnosis (including the ICD diagnosis codes)
d. Itemized description of the services and charges (including the CPT or HCPCS procedure codes)
e. Provider's tax ID number
f. Proof of payment. This can be a credit card/bank statement or cancelled check

Some claims will require additional information:

a. **Accidental injury**: Include the date, time, place and description of the accident
b. **Ambulance service**: Include where you were picked up and taken
c. **Out-of-country care**: Only covered when you have an emergency or need urgent care. When you get care outside the United States, include:
    i. Explanation of where you were and why you needed care
    ii. Copy of the medical record (translated if available)

If any of the charges are covered by the Plan, we will reimburse you.

9.1.2 Prescription Medication Claims

When you go to an in-network pharmacy, show your Moda Health ID card and pay your prescription cost sharing. You will not have to file a claim.

If you fill a prescription at an out-of-network pharmacy that does not access our claims payment system, or buy an OTC contraceptive, you will need to fill out and send in the prescription medication claim form. This form is on your Member Dashboard. We will reimburse you for any covered charges.

9.1.3 Explanation of Benefits (EOB)

We will tell you how we processed a claim in a document called an Explanation of Benefits (EOB). We may pay claims, deny them, or apply the allowable expense toward satisfying any deductible. If all or part of a claim is denied, we will tell you why in the EOB. We encourage you to access your EOBs electronically by signing up through your Member Dashboard.

If you do not receive an EOB or an email telling you that an EOB is available within a few weeks of the date of service, this may mean that we did not receive the claim. Your claim will not be paid unless we receive it within the claim submission period explained in section 9.1.

9.1.4 Claim Inquiries

The Health Navigator team can answer questions about how to file a claim, the status of a pending claim, or any action taken on a claim. We will respond to your inquiry within 30 days.

9.1.5 Time Frames for Processing Claims

You will hear from us no more than 30 days after we receive a claim.

a. If the claim is denied, we will send an EOB explaining the denial
b. If we need more time for reasons beyond our control, we will send you a notice of delay explaining those reasons. We will finish processing the claim no more than 45 days after we receive it
c. If we need more information, the notice of delay will describe the information we need. Whoever is responsible for providing the additional information will have 45 days to send it to us. We will finish processing the claim no more than 15 days after we get the additional information

We must receive all information we need to process your claim within the Plan's claim submission period explained in section 9.1.

If a service must be authorized, we will respond to the prior authorization request within 2 business days. If we ask for more information, we will finish the prior authorization request no more than 15 days after receiving the information. We will respond more quickly if you have an urgent medical condition.

9.2 COMPLAINTS, APPEALS & EXTERNAL REVIEW

Before you file an appeal, call the Health Navigator team. We may be able to resolve your problem over the phone.

9.2.1 Time Limit for Submitting Appeals

If your appeals are not on time, you will lose the right to any appeal.

a. You have **180 days** from the date you receive an adverse benefit determination to send us your first level appeal
b. You have **60 days** from the date of the first level appeal decision to send us your second level appeal

9.2.2 The Review Process

The Plan has a 2-level internal review process, a first level appeal and a second level appeal. If you are not satisfied with the result of the second level appeal, you may ask for external review by an independent review organization. You must finish the first and second levels of appeal before you can ask for external review, unless we agree to skip the internal reviews.

You may review the claim file and submit written comments, documents, records and other information to support your appeal. You may choose a person (representative) to act on your behalf. You must sign an authorization to disclose personal health information (PHI) allowing your representative to act for you. You may find this form on modahealth.com. Contact Customer Service for help assigning your representative.

How First and Second Level Appeals Work

a. Submit your appeal in writing, on time. If you need help, ask Customer Service
b. We will send you a letter no more than 7 days after we receive your appeal so you know we got it
c. Someone who was not involved in the original decision will investigate your appeal
d. We will send the decision to you within 15 days of a pre-service appeal or 30 days of a post-service appeal

If we use new or additional evidence or reasoning when deciding your second level appeal, we will share this with you. You may respond to this information before our decision (the final internal adverse benefit determination) is finalized.

Expedited Appeals

Appeals can have a faster review upon request. Review of appeals that meet the criteria to be expedited will be finished within 72 hours in total for the first and second level appeals combined after we have received those appeals. The time between the first level appeal decision and when we receive the second level appeal does not count.

If you do not provide enough information for us to make a decision, we need no more than 24 hours after we receive the appeal. We must get this information back as soon as possible. We will make a decision on an expedited appeal no more than 48 hours after the earlier of (a) our receipt of the information, or (b) the end of the time allowed to send us the information.

Special Circumstance

If the appeal is about ending or reducing an ongoing course of treatment before the end of the authorized period of time or number of treatments, we will continue to provide benefits while we review your appeal. If the decision is upheld, you will have to pay back the cost of the benefits you received during the review period.

The timelines for reviewing your appeal do not apply if:

a. You do not reasonably cooperate
b. Circumstances beyond your control or ours make it impossible. Whoever is unable to meet a timeline must give notice of the specific reason to the other when the issue arises

9.2.3 External Review

You may ask to have your appeal reviewed by an independent review organization (IRO) appointed by the Oregon Division of Financial Regulation.

a. The request for external review must be in writing to the Appeals Department (see section 2.1) no more than 180 days after you receive the final internal adverse benefit determination. If you need help with the request, ask the Health Navigator team. You may submit additional information to the IRO within 5 days, or 24 hours for an expedited review
b. You must have completed the appeal process described in section 9.2.2. We will send an appeal directly to external review if we both agree to skip this requirement. For an expedited appeal or when the appeal is about a condition for which you received emergency services and are still hospitalized, a request for external review may be expedited or at the same time as a request for internal appeal review

Only certain types of denials are eligible for external review. The IRO screens requests, and will review appeals that relate to

a. An adverse determination based on a utilization review decision
b. Whether surprise billing protections apply to an adverse benefit determination
c. Whether the treatment is an active course of treatment for purposes of continuity of care (see section 9.3)
d. Recission of coverage (section 11.8.3)
e. Cases in which we have not met the internal timeline for review or the federal requirements for providing related information and notices

The decision of the IRO is binding except to the extent other remedies are available to you under state or federal law. If we fail to comply with the decision, you have the right to sue.

A final internal adverse benefit determination based on specific exclusions or limitations on the amount, duration or scope of coverage that does not involve medical judgment or a decision on whether you are a member under the Plan does not qualify for external review. A complaint decision does not qualify for external review.

9.2.4 Complaints

Submit your complaint in writing within 180 days from the date of the problem or claim. We will review complaints about:

a. Availability, delivery or quality of a health care service
b. Claims payment, handling or reimbursement for healthcare services that is not appealing an adverse benefit determination
c. The contractual relationship between us

We will finish reviewing your complaint within 30 days. If we need more time, we will send you a letter letting you know about the delay. We will have 15 more days to make a decision.

9.2.5 Definitions

For purposes of section 9.2, the following definitions apply:

Adverse Benefit Determination is a letter or an Explanation of Benefits (EOB) from us telling you that you are not eligible for benefits or that benefits have not been fully paid. Reasons are:

a. Rescission of coverage (section 11.8.3)
b. Eligibility to participate in the Plan
c. Network exclusion, annual benefit limit or other limitation on otherwise covered services
d. Utilization review (described below)

e. Limitations or exclusions described in Section 7 or Section 8, including a decision that an item or service is experimental or investigational or not medically necessary
f. Continuity of care (section 9.3) is denied because the course of treatment is not considered active

A **Final Internal Adverse Benefit Determination** is an adverse benefit determination that we have upheld at the end of the internal appeal process. The internal appeal process is finished.

Appeal is a written request by you or your representative for us to review an adverse benefit determination.

Authorized Representative means an individual who by law or by the consent of a person may act on behalf of the person.

Complaint is an expression of dissatisfaction about a specific problem you have had or about a decision by us or someone acting for us or a provider. It includes a request to resolve the problem or change the decision. Asking for information or clarification about the Plan is not a complaint.

Expedited appeal is a pre-service appeal that needs a faster review because using the regular time period to review it could
a. Seriously risk your life or health or ability to regain maximum function
b. Would subject you to severe pain that cannot be managed without the requested care or treatment. A physician with knowledge of your medical condition decides this

Post-service appeal is any appeal about care or services that you have already received.

Pre-service appeal is any appeal about care or services that must be prior authorized and you have not had the services yet.

Utilization Review is how we review the medical necessity, appropriateness or quality of medical care services and supplies. These adverse benefit determinations are examples of utilization review decisions:
a. The care is not medically necessary or appropriate
b. The care is investigational or experimental
c. The decision about whether a benefit is covered involved a medical judgment

9.3 CONTINUITY OF CARE

Sometimes a provider's contract with the network ends. On the day a provider's contract with us ends, they become an out-of-network provider. When this happens, we may cover some services by the provider as if they were still in-network for a limited period of time. This is called continuity of care.

If you are under the care of a particular provider when their contract with us ends, you should get a letter from us or the provider group telling you about your right to continuity of care. If you ask for continuity of care before you get this letter, you are considered notified as of that date.

Continuity of care is not automatic. You must request continuity of care from us.

In addition:

a. Your provider must reasonably believe you have special circumstances that cause you harm if you were to discontinue treatment with them
b. Your provider must agree to follow the requirements of their most recent medical services contract with us, and to accept the contractual reimbursement applicable at the time the contract ended

Special circumstances that make you eligible for continuity of care are:

a. Your care is an active course of treatment that is medically necessary. This includes pregnancy and institutional or inpatient care
b. You are being treated for a serious and complex condition. This may be a disability, chronic condition, or an acute or life-threatening illness.
c. You are scheduled for a nonelective surgery. Both the surgery and the postoperative care are covered under this provision.

Continuity of care ends on the earlier of the following dates for most members who are getting ongoing care from their provider:

a. The day after you finish the treatment or are no longer diagnosed with the condition that triggered your right to continuity of care
b. 90 days after the date you were told the contract with your provider had ended if your continuity of care is for inpatient or other facility care
c. 120 days after the date you were told the contract with your professional provider had ended if your continuity of care is for professional provider care

If you are receiving pregnancy care, continuity of care ends on the later of the following dates:

a. 45 days after your baby is born
b. Inpatient or facility care may be continued up to 90 days after the date you were told the contract with your provider had ended
c. If you continue active treatment, professional provider care may be continued not later than 120 days after the date you were told the contract with your professional provider had ended

Continuity of care is not available if:

a. You leave the Plan
b. The Group ends the Plan
c. The provider has moved out of the service area
d. The provider cannot continue to care for patients for other reasons
e. The contract with the provider ended for reasons related to quality of care and they have finished any appeals process

9.4 BENEFITS AVAILABLE FROM OTHER SOURCES

Sometimes healthcare expenses may be the responsibility of someone other than Moda Health.

9.4.1 Coordination of Benefits (COB)

Coordination of benefits applies when you have healthcare coverage under more than one plan. If you are covered by another plan or plans, the benefits under this Plan and the other plan(s) will be coordinated. This means one plan pays its full benefits first, and then any other plans pay. The Plan follows the order of benefit determination rules in the Oregon Administrative Rules.

These rules decide which plan is primary and pays a claim for benefits first. (For coordination with Medicare, see section 9.4.2.)

COB can be very complicated. This is a summary of some of the more common situations where you may have double coverage. It is not a full description of all of the COB rules. If your situation is not described here, contact Customer Service for more information.

9.4.1.1 When this Plan Pays First

This Plan is primary and will pay first if the claim is for:

a. The subscriber's own healthcare expenses
b. Your covered child's expenses when you are the subscriber and
    i. You birthday is earlier in the year than the other parent's and you are married, domestic partners or living together, or if there is a court decree assigning joint custody without specifying that one parent is responsible for healthcare expenses
    ii. You are separated, divorced or not living together and you have informed us of a court decree that makes you responsible for the child's healthcare expenses
    iii. If you are separated, divorced or not living together. There is not a court decree, but you have custody of the child

If you are a covered child on this Plan and also covered by your spouse's or domestic partner's plan, the plan that has covered you the longest is primary.

9.4.1.2 How COB Works

When we are the primary plan, we will pay benefits as if there was not any other coverage.

If we are the secondary plan, the primary plan will pay its full benefits first. We will need a copy of your primary plan's EOB so we can see what they paid. If there are covered expenses that the primary plan has not paid, such as deductibles, copayments or coinsurance, we may pay some or all of those expenses.

a. We will calculate the benefits we would have paid if you did not have any other healthcare coverage. We will apply that amount to any allowable expense that the primary plan did not pay
b. We will credit any amount to the deductible that would have been applied if you did not have other coverage
c. We will reduce the benefits we pay so that payments from all plans are not more than 100% of the total allowable expense
d. If the primary plan did not cover an expense because you did not follow that plan's rules, we will not cover that expense either. An example is if your primary plan did not cover an expense because you did not get prior authorization when it was required

If the primary plan is a closed panel plan (HMO is an example) and you use an out-of-network provider, we will provide benefits as if we are the primary plan, except for emergency services or authorized referrals that are paid or provided by the primary plan.

Any plan that does not follow Oregon's COB rules is always primary.

9.4.1.3 Definitions

For purposes of section 9.4.1, the following definitions apply:

Plan is any of the following that provide benefits or services for medical or dental care or treatment:

a. Group or individual insurance contracts and group-type contracts
b. HMO (health maintenance organization) coverage
c. Coverage under a labor-management trusteed plan, a union welfare plan, an employer organization plan or an employee benefits plan
d. Medical care components of group long-term care contracts, such as skilled nursing care
e. Medicare or other government programs, other than Medicaid, and any other coverage required or provided by law
f. Other arrangements of insured or self-insured group or group-type coverage

Each contract or other arrangement for coverage described above is a separate plan. If a plan has 2 parts and COB rules apply to only one of the 2, each of the parts is treated as a separate plan.

If separate contracts are used to provide coordinated coverage for covered persons in a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

Plan does not include:

a. Hospital indemnity coverage or other fixed indemnity coverage
b. Accident-only or school accident coverage
c. Specified disease or specified accident coverage
d. Benefits for non-medical components of group long-term care policies
e. Medicare supplement policies
f. Medicaid policies
g. Coverage under other federal governmental plans, unless permitted by law

Allowable expense is a healthcare expense, including cost sharing, that is covered at least in part by any plan you have coverage under. When a plan provides benefits in the form of a service instead of cash payments, the reasonable cash value of the service is considered an allowable expense and a benefit paid.

These are not allowable expenses:

a. Any expense that is not covered by any plan covering you
b. Any expense a provider is not allowed to charge you

9.4.2 Coordination with Medicare

We coordinate benefits with Medicare as required under federal law. This includes coordinating to the Medicare allowable amount. If the Plan is secondary to Medicare, we will not pay any expenses incurred from providers who have chosen not to participate in Medicare.

9.4.3 Third Party Liability

The rules for third party liability, including motor vehicle and other accidents, and surrogacy, are complicated and specific. We have included some high-level information here. Contact Customer Service for more information.

The Plan does not cover benefits when someone else - a third party - is legally responsible. This may include a person, a company or an insurer. Recovery from a third party may be difficult and take a long time, so we will pay your covered expenses based on the understanding and

agreement that we are entitled to be reimbursed for any benefits paid that are or may be recoverable from a third party.

You agree to do whatever is necessary to fully secure and protect our right of recovery on behalf of the Plan or subrogation. Subrogation refers to substituting one party for another in a legal setting. We are entitled to all subrogation rights and remedies under common and statutory law, as well as under the Plan. You will cooperate with us to protect our subrogation and recovery rights. This includes signing and delivering any documents we reasonably require to protect our rights and providing any information or taking actions that will help us recover costs from a third party.

a. If we pay claims that are, or are alleged to be, the responsibility of a third party, you hold any rights of recovery against the third party in trust for us.

b. We are entitled to be reimbursed for any benefits the Plan pays out of any recovery from a third party if there is a settlement or judgment against the third party. This is so whether or not the third party admits liability or claims that you are also at fault. We are entitled to receive the amount of benefits the Plan has paid whether the health care expenses are itemized or expressly excluded in the third party recovery.

c. If we, on behalf of the Plan, require you and your attorney to protect our recovery rights under this section, then you may subtract from the money to be paid back to the Plan a proportionate share of reasonable attorney fees as an expense for collecting from the other party.

d. Even without your written authorization, we may release to, or obtain from, any other insurer, organization or person, any information we need to carry out the provisions of section 9.4.3.

e. If it is reasonable to expect that you will have future expenses for which the Plan might pay benefits, you will seek recovery of such future expenses in any third party claim.

f. Section 9.4.3 applies to you if the Plan advances benefits whether or not the event causing your injuries occurred before you became covered by Moda Health.

If you or your representatives do not comply with the requirements of this section, then we may not advance payment or may suspend payment of any benefits, or recover any benefits we have advanced, for any medical condition related to the third party claim except for claims related to motor vehicle accidents (see section 9.4.3.1). We may notify medical providers seeking payment that all payments have been suspended and may not be paid.

9.4.3.1 Motor Vehicle Accident Recovery

If you file a claim with us for healthcare expenses due to a motor vehicle accident and motor vehicle insurance has not yet paid, we, as administrator of the Plan, will advance benefits. We, on behalf of the Plan, have the right to be repaid from the proceeds of any settlement, judgement or other payment you receive that exceeds the amount that fully compensates you for your motor vehicle accident related injuries.

If we, on behalf of the Plan, require you or your attorney to protect our recovery rights under this section, then you may subtract from the money to be paid back to the Plan a proportionate share of reasonable attorney fees as an expense for collecting from the other party.

You will do whatever is required to secure, and may not prejudice, our rights under this section.

9.4.4 Surrogacy

If you enter into a surrogacy agreement, you must reimburse the Plan for covered services related to conception, pregnancy, delivery and postpartum care that you receive in connection with the surrogacy agreement. By accepting services, you give us, as administrator of the Plan, the right to receive payments you receive or are entitled to receive under the surrogacy agreement. Within 30 days after entering a surrogacy agreement, you must inform us and send us a copy of the agreement.

SECTION 10. ELIGIBILITY

The Plan's eligibility rules are outlined in the Oregon Administrative Rules under OAR 111-015-0001. The date a person becomes eligible may be different than the date coverage begins. More specific information can be found in Section 11.

10.1 ELIGIBILITY AUDIT

We have the right to make sure you are eligible. We may ask for documentation including but not limited to member birth certificates, adoption paperwork, marriage or domestic partnership documentation and any other evidence necessary to document your eligibility for the Plan.

SECTION 11. ENROLLMENT

11.1 NEWLY-HIRED AND NEWLY-ELIGIBLE ACTIVE ELIGIBLE EMPLOYEES

The Plan's enrollment rules for newly-hired and newly-eligible active eligible employees are outlined in the Oregon Administrative Rules under OAR 111-040-0010.

11.2 QUALIFIED STATUS CHANGES

The Plan's enrollment rules for qualified status changes are outlined in the Oregon Administrative Rules under OAR 111-040-0040.

An eligible employee and their spouse, registered domestic partner, and/or children may also have additional enrollment rights under Medicaid or a children's health insurance program (CHIP) and such coverage was terminated due to loss of eligibility. Special enrollment must be requested within 60 days of the termination.

Additionally, if an eligible employee, spouse, domestic partner or child covered under Medicaid or CHIP becomes eligible for a premium assistance subsidy, and special enrollment is requested within 60 days of the determination of eligibility, they may enroll in the Plan outside of the open enrollment period.

The special enrollment rights as described above apply:

a. To an eligible employee who loses other coverage or becomes eligible for a premium assistance subsidy
b. To a spouse, domestic partner, or child who loses coverage under the other plan or becomes eligible for a premium assistance subsidy
c. To both if neither is enrolled in the Plan, and either loses coverage under the other plan or becomes eligible for a premium assistance subsidy

To enroll, an eligible employee must submit a complete and signed application within the required timeframe, along with a certificate of creditable coverage from the previous plan.

Note: A new dependent may cause a premium to go up. Any premium will apply from the date coverage is effective (during the first 60 days of coverage for newborn or adopted children). If payment is not submitted when required, the child will not be covered. A signed copy of court-ordered guardianship will be required for coverage of a grandchild.

11.3 EFFECTIVE DATES

The Plan's effective dates for enrollment are outlined in the Oregon Administrative Rules under OAR 111-040-0001.

11.4 OPEN ENROLLMENT

The Plan's open enrollment rules are outlined in the Oregon Administrative Rules under OAR 111-040-0020.

11.5 LATE ENROLLMENT

The Plan's late enrollment rules are outlined in the Oregon Administrative Rules under OAR 111-040-0030.

11.6 RETURNING TO ACTIVE ELIGIBLE EMPLOYEE STATUS

The Plan's enrollment rules for those persons returning to active eligible employee status are outlined in the Oregon Administrative Rules under OAR 111-040-0011.

All plan provisions will resume at re-enrollment whether or not there was a lapse in coverage. Any exclusion period that was not completed at the time the subscriber was laid off or had a reduction in hours must be satisfied. The period of layoff or reduction in hours will be counted toward any exclusion period. Upon re-enrollment in the Plan, any waiting period required by the Plan will not have to be re-served.

11.7 REMOVING AN INELIGIBLE INDIVIDUAL FROM BENEFIT PLANS

The Plan's rules for removing an ineligible person from the Plan are outlined in the Oregon Administrative Rules under OAR 111-040-0015.

A subscriber is responsible for notifying the Group if a dependent becomes ineligible for the Plan within 31 days of the qualified status change. A subscriber's failure to report a qualified status change within 31 days is considered an intentional misrepresentation of fact which is material to enrollment in the Plan and may be grounds to terminate the benefits of an ineligible dependent effective the first of the month following the loss of eligibility.

11.8 WHEN COVERAGE ENDS

Termination dates for loss of eligibility, death of the active eligible employee, and retirement of the active eligible employee are outlined in the Oregon Administrative Rules under OAR 111-040-0005. When the subscriber's coverage ends, coverage for all enrolled dependents also ends. In addition, there are a variety of other circumstances in which a member's coverage will end. These are described in the following paragraphs.

11.8.1 The Group Plan Ends

Coverage ends for OEBB as a whole and members on the date the Plan ends. There is one exception to this rule. If OEBB ends the Plan and immediately replaces it with a policy through another carrier, and you are hospitalized on the day the Plan coverage ends, your coverage under the Plan continues until you are discharged from the hospital if your stay meets medical necessity criteria.

Moda Health may terminate the group policy for fraud or intentional misrepresentation of material fact by OEBB, or for OEBB's noncompliance with material policy provisions.

If the policy is ended for a reason other than nonpayment of premiums and OEBB does not replace the coverage, Moda Health will mail a notice of termination to OEBB. Group plan termination includes termination of a multiple-employer trust policy. Moda Health's notice will be mailed within 10 working days of the date of termination. The notice will explain members' rights under federal and state law regarding and continuation of coverage. It is the responsibility of OEBB to send the information contained in the notice to members.

If Moda Health does not give notice as required by this provision, the group policy shall remain in full force from the date notice should have been provided until the date the notice is received by OEBB, and Moda Health will waive the premiums owing for this period. In this case, the period during which members have to apply for continuation coverage will begin on the date OEBB receives the notice.

11.8.2 Subscriber Ends Coverage

A subscriber may end their coverage, or coverage for any enrolled dependent, by giving Moda Health written notice through OEBB in accordance with OEBB's administrative rules, unless the coverage election is considered irrevocable for the plan year (such as when the employee's share of the premium is withheld from their paycheck on a pretax basis). Coverage ends on the last day of the month through which premiums are paid.

11.8.3 Rescission By The Plan

The Plan's enrollment rules for rescission by the Plan are outlined in OEBB's Administrative Rules. Members may also refer to the OEBB Member Benefits Guide for additional information on rescinding.

11.8.4 Other

Information is in Continuation of Health Coverage (Section 12).

11.9 DECLINATION OF COVERAGE

The Plan's rules for declining coverage are outlined in the Oregon Administrative Rules under OAR 111-040-0050.

SECTION 12. CONTINUATION OF HEALTH COVERAGE

The Plan's continuation of coverage rules are outlined in the Oregon Administrative Rules under OAR 111-050-0001 through OAR 111-050-0080. Additional guidance on how to obtain continuation of coverage is outlined in the following sections.

12.1 COBRA CONTINUATION COVERAGE

COBRA continuation coverage does not apply to all groups. Check with the Group to find out if this Plan qualifies. In this COBRA section, COBRA Administrator means either the Group or the third party administrator they have assigned to handle COBRA administration. Your coverage under COBRA continuation will be the same as that for other members under the Plan.

You may elect COBRA if you are the subscriber and you lose coverage because your employment ended (other than for gross misconduct), or your hours are reduced.

Be sure to look at *Special Circumstances at the end of the COBRA section.

If you are the spouse or child of the subscriber, COBRA is available if you lose coverage because of:

a. The subscriber's death
b. The subscriber's employment ends (other than for gross misconduct) or their hours of employment with the Group are reduced
c. The subscriber becomes entitled to Medicare
d. Divorce or legal separation from the subscriber*
e. You no longer meet the definition of "child" under the Plan

You must provide written notice to the COBRA Administrator if one of these events occurs. Include: 1) the name of the Group; 2) the name and social security number of the affected members; 3) the event (such as divorce): and 4) the date the event occurred. You must give notice no later than 60 days after you lose coverage under the Plan. If notice of the event is not given on time, COBRA is not available.

Electing COBRA. You must elect COBRA within 60 days after plan coverage ends, or, if later, 60 days after the COBRA Administrator sends you notice of your right to elect COBRA. Each family member* has an independent right to elect COBRA coverage. This means that a spouse or child may elect COBRA even if the subscriber does not.

You are responsible for all COBRA premiums. Due to the 60-day election period, you will owe retroactive premiums for the months between when regular coverage ended and the first payment date. You must pay these premiums in a lump sum at the first payment. The first payment is due within 45 days after you elect coverage (this is the date the election notice is postmarked, if mailed, or the date the COBRA Administrator receives it, if hand-delivered). The premium rate may include a 2% add-on to cover administrative expenses.

All other payments are due on the 1st of the month. You will not receive a bill. You are responsible for paying your premiums when due. If your premiums are not received on time, your COBRA

coverage will end and may not be reinstated. You will have a 30-day grace period to pay the premiums.

Length of COBRA
COBRA due to end of employment or a reduction of hours of employment generally lasts up to 18 months. COBRA because of a subscriber's death, divorce or legal separation, or a child ceasing to be a dependent under the terms of the Plan, can last up to a total of 36 months.

If the subscriber became entitled to Medicare less than 18 months before their employment ends or their hours are reduced, COBRA for members (other than the subscriber) who lose coverage because of the employment end/reduction in hours can last up to 36 months after the date of Medicare entitlement.

You and your family may be eligible for a longer period of COBRA coverage if you are disabled or a second qualifying event occurs. You must notify the COBRA Administrator within 60 days of a second qualifying event or becoming disabled. If you do not, you will lose the right to extended COBRA coverage.

If the Social Security Administration determines you are disabled, your 18-month COBRA period may be extended to a total of up to 29 months. The disability must have started before the 61st day of your COBRA coverage period. The Social Security Administration must make its decision before the end of your initial 18-month COBRA period. You must give a copy of the Social Security Administration's determination of disability to the COBRA Administrator no more than 60 days after the latest of:

a. the date of the Social Security Administration's disability determination
b. the date of the subscriber's termination of employment or reduction of hours
c. the date on which you lose (or would lose) coverage under the terms of the Plan as a result of the subscriber's termination or reduction of hours of employment

Each family member on COBRA can have the disability extension if one of you qualifies. Your COBRA premiums may increase after the 18th month of coverage to 150% of the premium. Your disability extension ends if you are no longer considered disabled.

If you are a spouse or child on COBRA and a second qualifying event occurs, your maximum COBRA period may be extended to 36 months from the date of the first qualifying event. Second qualifying events may include the death of the subscriber, divorce or legal separation from the subscriber, or a child's no longer being eligible as a dependent under the Plan. These are a second qualifying event only if they would have caused you to lose coverage if the first qualifying event had not occurred.

Note: Longer continuation coverage may be available under Oregon Law for a subscriber's spouse or domestic partner age 55 and older who loses coverage due to the subscriber's death, or due to legal separation or dissolution of marriage or domestic partnership (see section 12.2).

When COBRA Ends
COBRA coverage ends after the maximum COBRA period. It will end earlier if your premiums are not paid on time or the Group stops offering any group health plan to its employees. COBRA will also end if:

a. You become covered under another group health plan

b. You become entitled to Medicare benefits after electing COBRA (unless the qualifying event is the Group's bankruptcy)
c. Any reason the Plan would end coverage if you were not on COBRA (such as fraud)

Ask the COBRA Administrator if you have any questions about COBRA. Don't forget to tell the COBRA Administrator if your address changes.

***Special Circumstances**
References within the COBRA section to spouse apply to a domestic partner unless otherwise stated. For divorce or legal separation, termination of domestic partnership applies for domestic partners.

Divorce or legal separation may be a qualifying event even if the subscriber ended your coverage earlier. If you notify the COBRA Administrator within 60 days of the divorce or legal separation, COBRA may be available for the period after the divorce or legal separation.

If the Plan provides retiree coverage and the subscriber's former employer files for bankruptcy, this may be a qualifying event if you lose coverage as a result. Contact the COBRA Administrator for more information about this situation.

12.2 RETIREES

The Plan's continuation rules for retirees are outlined in the Oregon Administrative Rules under OAR 111-050-0010 through 111-050-0050.

12.3 55+ OREGON CONTINUATION

55+ Oregon Continuation applies to employers with 20 or more employees. It provides continuation coverage for spouses and domestic partners age 55 and older who are not eligible for Medicare. If you lose coverage because the subscriber died or your marriage or domestic partnership with the subscriber ended, you may elect 55+ Oregon Continuation coverage for yourself and any enrolled dependents if you meet all the requirements.

You must notify the Group or its third-party administrator within 60 days from the date your marriage or domestic partnership is legally ended or within 30 days after the subscriber has died. Include your mailing address. You will be given information about how to sign up for continuation coverage and pay premiums. If you do not elect 55+ Continuation on time, you will lose the right to this continuation coverage.

Your coverage will end if you do not pay on time, or if the Plan as a whole ends. Otherwise, 55+ Oregon Continuation ends when you become insured under any other group health plan, you become eligible for Medicare, or you remarry or register another domestic partnership.

If the Group or its third-party administrator does not notify you of your continuation rights, the Group is responsible for premiums from the date the notice was required until the date you receive the notice.

12.4 UNIFORMED SERVICES EMPLOYMENT & REEMPLOYMENT RIGHTS ACT (USERRA)

If the subscriber is called to active duty by any of the armed forces of the United States of America, they may continue coverage under USERRA for up to 24 months or the period of uniformed service leave, whichever is shortest. You must continue to pay your share of the premiums during the leave.

If you do not elect continued coverage under USERRA, or you cancel or use up your USERRA continuation, coverage restarts on the day you return to active employment with the Group. All plan provisions and limitations apply as if your Plan coverage had been continuous. You must be released under honorable conditions, and return to active employment within the required timeframe. You can get complete information about your rights under USERRA from the Group.

12.5 FAMILY & MEDICAL LEAVE

You will remain eligible for coverage during a leave of absence under state or federal family and medical leave laws. If you choose not to stay enrolled, you will be eligible to re-enroll in the Plan on the date the subscriber returns to work. Submit a complete and signed application within 60 days of the return to work. Your coverage will re-start as if there had been no break in coverage.

12.6 LEAVE OF ABSENCE

The participating organization may choose to allow you a leave of absence from work for any reason. You are still considered employed and can continue your coverage. If you are on leave for a family and medical leave-qualifying reason based on OAR 111-050-0070. Premiums must be paid through the OEBB in order to maintain coverage during a leave of absence.

12.7 WORKERS' COMPENSATION

If you have a work-related medical condition and are not working enough hours to be eligible because of it, you may continue your coverage for up to 6 months. You must have filed a workers' compensation claim. You must pay the full premiums to the Group. The Group must pay the premiums to us when due. This continuation happens at the same time as any family medical leave. You can elect other continuation of coverage after the end of this continuation. Your workers' Compensation continuation will end early if you become employed full-time with another employer.

12.8 STRIKE OR LOCKOUT

If you are employed under a collective bargaining agreement and involved in a work stoppage because of a strike or lockout, you must pay the full premiums, including any part usually paid by the Group, to the union or trust. The union or trust must send the premiums to us when due.

Continuation of coverage during a strike or lockout will not occur if:

a. Fewer than 75% of those normally enrolled choose to continue their coverage
b. You become employed full-time with another employer
c. You lose eligibility under the Plan for other reasons

SECTION 13. DEFINITIONS

Terms used but not otherwise defined in this handbook shall have the same meaning as those terms in the OEBB Administrative Rules.

Ancillary Services are support services provided to you in the course of care. They include such services as laboratory and radiology.

Authorization see Prior Authorization.

Autism Spectrum Disorder refers to the meaning as provided in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) published by the American Psychiatric Association.

Balance Billing is the difference between the maximum plan allowance (MPA) and the provider's billed charge. You will have to pay this amount when you choose to use an out-of-network provider. You cannot be balance billed if an out-of-network provider is performing services at an in-network facility and you did not choose the provider, or when otherwise prohibited by law. Balance billing is not a covered expense under the Plan.

Behavioral Health refers to mental health and/or substance use disorder and the services to treat these conditions.

Coinsurance is a percentage of covered expense that you pay. If your coinsurance is 20%, you pay 20% of the allowable expense and we pay the other 80%.

Copay or **Copayment** is a fixed dollar amount you pay to a provider when you get a covered service. For example, you may have a $25 copay every time you see your primary care physician. This would be all you pay for the office visit (but other services you get at the same time may have other cost sharing).

Cost Sharing is the share of costs you must pay when you get a covered service. It includes deductible, copayments or coinsurance. Cost sharing does not include premiums, balance billing amounts for out-of-network providers or the cost of non-covered services.

Covered Service is a service or supply that is specifically described as a benefit of the Plan.

Custodial Care means care that helps you conduct common activities such as bathing, eating, dressing, getting in and out of bed, preparation of special diets and supervision of medication that usually can be self-administered. It is care that can be provided by people without medical or paramedical skills.

Deductible is the amount of covered expenses you must pay before the Plan starts paying. If you get services from both in-network and out-of-network providers, 2 separate deductibles may apply.

Dental Care is services or supplies to prevent, diagnose or treat diseases of the teeth and supporting tissues or structures such as your gums. It includes services or supplies to restore your ability to chew and to repair defects that have developed because of tooth loss.

Emergency Medical Condition is a medical condition or behavioral health crisis with acute symptoms, including severe pain, that a prudent layperson with an average knowledge of health and medicine could reasonably expect would place the health or mental health of a member, or a fetus in the case of a pregnant member, in serious jeopardy without immediate medical or behavioral health attention. A behavioral health crisis is a disruption in a person's mental or emotional stability or functioning resulting in an urgent need for immediate outpatient treatment in an emergency department or admission to a hospital to prevent a serious deterioration in the person's mental or physical health.

Emergency Medical Screening Examination is the medical history, examination (which may include behavioral health assessment), related tests and medical determinations required to confirm the nature and extent of an emergency medical condition. A behavioral health assessment is an evaluation by a behavioral health provider, in person or using telemedicine, to determine a person's need for immediate crisis stabilization.

Emergency Services are emergency medical services transport as well as healthcare items and services you get in an emergency department of a hospital. All related services routinely available to the emergency department to the extent they are required to stabilize a member, and further medical examination and treatment required to stabilize a member and within the capabilities of the staff and facilities available at the hospital, are included.

At an out-of-network emergency care facility, emergency services may also include post-stabilization services such as outpatient observation or an inpatient or outpatient stay, unless the attending physician determines you are able to travel using nonmedical or nonemergency transportation to an in-network facility. If you are able to travel and you give informed consent for out-of-network care according to state and federal requirements, then post-stabilization services are not emergency services.

Enroll means to become covered for benefits under the Plan. You are enrolled when your coverage becomes effective, not at the time you have completed or filed any enrollment forms needed to become covered. You are enrolled in the Plan whether you elect coverage, you are a spouse, domestic partner, or child who becomes covered as a result of an election by the subscriber, or you become covered without an election.

Experimental or Investigational means services, supplies and medications that meet one of the following:

a. Involve a treatment for which scientific or medical assessment has not been completed, or the effectiveness of the treatment has not been generally established. This includes a treatment program that may be proven for some uses, but scientific literature does not support the use as requested or prescribed. An example is a medication that is proven as a treatment when used alone, but scientific literature does not support using it in combination with other therapies.
b. Are available in the United States only as part of clinical trial or research program for the illness or condition being treated
c. Are not provided by an accredited institution or provider within the United States or are provided by one that has not demonstrated medical proficiency in the provision of the service or supplies
d. Are not recognized by the medical community in the service area in which they are received

e. Involve a treatment for which the approval of one or more government agencies is required, but has not been obtained at the time the services and supplies are provided or are to be provided

Group Health Plan is a health benefit plan that is made available to the eligible persons of the organization.

Health Benefit Plan is any hospital and/or medical expense policy or certificate, healthcare service contractor or health maintenance organization subscriber contract, any plan provided by a multiple employer welfare arrangement, or other benefit arrangement defined in the federal Employee Retirement Income Security Act of 1974, as amended. This Plan is a health benefit plan.

Illness is a disease or bodily disorder that results in a covered service.

Implant is a material inserted or grafted into tissue.

Injury is physical damage to your body caused by a foreign object, force, temperature or corrosive chemical. It is the direct result of an accident, independent of illness or any other cause.

In-Network refers to providers contracted under one of our approved networks to provide care to you.

Maximum Plan Allowance (MPA) is the maximum amount the Plan will reimburse providers. For an in-network provider, the MPA is the amount the provider has agreed to accept for a particular service.

MPA for out-of-network services is either a supplemental provider fee arrangement we may have in place or the amount calculated using any one of the following methods: a percentage of the Medicare allowable amount, a percentage of the allowable amount established by the Oregon Health Authority, a percentile of fees commonly charged for a given procedure in a given area, a percentage of the acquisition cost or a percentage of the billed charge.

MPA for emergency services you get out-of-network, out-of-network air ambulance, or out-of-network services in an in-network facility where you are not able to choose the provider is based on the median in-network rate. Otherwise, the MPA is the amount determined by state guidelines.

MPA for prescription medications at out-of-network pharmacies is no more than the prevailing pharmacy network fee based on the average wholesale price (AWP) minus a percentage discount.

In certain instances, when a dollar amount is not available, we review the claim to determine a comparable code to the one billed. The claim is processed using the comparable code and as described above.

When you use an out-of-network provider, you may have to pay any amount over the MPA (this is the balance billing amount) except when balance billing is prohibited by law.

Medical Condition is any physical or mental condition, including one resulting from illness, injury (whether or not the injury is accidental), pregnancy or birth defect. Genetic information in and of itself is not a condition. Genetic information is information related to you or your relative

about genetic tests, a request for or receipt of genetic services, or participation in clinical research that includes genetic services. It also includes a relative's disease or disorder.

Medically Necessary means healthcare services, medications, supplies or interventions that a treating licensed healthcare provider recommends and all of the following are met:

a. It is consistent with the symptoms or diagnosis of your condition and appropriate considering the potential benefit and harm to you
b. The service, medication, supply or intervention is known to be effective in improving health outcomes
c. The service, medication, supply or intervention is cost effective compared to the alternative intervention, including no intervention

The fact that a provider prescribes, orders, recommends or approves a service or supply does not, of itself, make the service medically necessary or a covered service.

We may require proof that services, interventions, supplies or medications (including court-ordered care) are medically necessary. No benefits will be paid if the proof is not received or is not acceptable, or if the service, supply, medication or medication dose is not medically necessary. Claims processing may be delayed if we require proof of medical necessity and it is not provided by the health service provider.

We use scientific evidence from peer-reviewed medical literature to determine effectiveness for services and interventions for the medical condition and patient indications being considered.

Medically necessary care does not include custodial care. See Treatment Not Medically Necessary in General Exclusions (Section 8) for more information.

Member is a subscriber, spouse, eligible domestic partner or child. Where this book refers to "you" or "your" it is referring to a member.

Mental Health Condition is any mental health disorder covered by the diagnostic categories listed in the most current edition of the International Classification of Disease or Diagnostic and Statistical Manual of Mental Disorders.

Mental Health Provider is any of the following state-licensed professionals:

a. Board-certified psychiatrist
b. Psychologist or psychologist associate
c. Psychiatric mental health nurse practitioner
d. Clinical social worker, mental health counselor or marriage and family therapist
e. A program licensed, approved, established, maintained, contracted with or operated by the Oregon Office of Mental Health & Addiction Services
f. An associate or resident in the field of counseling, marriage and family therapy, social work or psychology who is practicing under a board-approved supervision plan and working for a provider who is contracted and credentialed with Moda Health

Moda Health refers to Moda Health Plan, Inc. Where this book refers to "we", "us" or "our" it is referring to Moda Health or its employees.

Network is a group of providers who contract to provide healthcare to you at negotiated rates. These groups are called Preferred Provider Organizations (PPOs), and provide in-network services

in their specific service areas. See Section 5 for more information about networks. Covered medical expenses are paid at a higher rate when an in-network provider is used, as shown in Section 3.

OEBB means the Oregon Educators Benefit Board.

Out-of-Network refers to providers that are not contracted under one of our approved networks to charge discounted rates to you.

Out-of-Pocket Maximum is the maximum amount you pay out-of-pocket every plan year. It includes the deductible, coinsurance and copays. If you get services both in-network and out-of-network services, 2 separate out-of-pocket maximums may apply. If you reach the out-of-pocket maximum in a plan year, the Plan will pay 100% of your eligible expenses for the rest of the year.

A **PCP 360** is a high quality primary care provider willing to partner with members and be accountable for their health. PCP 360s provide higher quality care with lower out of pocket cost. Members must choose and use a PCP 360 to receive the better benefits of coordinated care (see section 5.2).

The **Plan** is the health benefit plan sponsored by OEBB and offered through a minimum premium arrangement under the terms of the policy between OEBB and Moda Health.

Plan Year is the twelve month period beginning October 1st and ending September 30th. All deductibles, maximums and limitations shall be accrued on a plan year basis.

The **Policy** is the agreement between OEBB and Moda Health regarding the health benefit plan sponsored by OEBB. This handbook is a part of the policy.

Primary Care Physician (PCP) is the in-network physician or women's healthcare provider you choose to be responsible for your medical care.

Prior Authorization or **Prior Authorized** refers to getting approval from us before the date of service. A complete list of services and medications that require prior authorization is available on your Member Dashboard or you can ask the Health Navigator team. A service, supply or medication that is not prior authorized when required will not be covered (see section 6.1).

Professional Provider is any state-licensed or state-certified healthcare professional, when providing medically necessary services within the scope of their license or certification.

Provider is an entity, including a facility, a medical supplier, a program or a professional provider, that is state-licensed or state-certified and approved to provide a covered service or supply.

Service Area is the geographical area where in-network providers provide their services.

Subscriber is any eligible employee or early retiree who is enrolled in the Plan.

Waiting Period is the period that must pass before you are eligible to enroll for benefits under the terms of the Plan.

SECTION 14. GENERAL PROVISIONS & LEGAL NOTICES

14.1 MEMBER DISCLOSURES

What are my rights and responsibilities as a Moda Health member?
You have the right to:

a. Information about the Plan and how to use it, the providers who will care for you, and your rights and responsibilities
b. Be treated with respect and dignity
c. Urgent and emergency services, 24 hours a day, 7 days a week
d. Participate in decision making regarding your healthcare. This includes
    i. changing to a new primary care physician (PCP)
    ii. a discussion of appropriate or medically necessary treatment options, no matter how much they cost or if they are covered
    iii. the right to refuse treatment and be informed of the possible medical result
    iv. filing a statement of wishes for treatment (i.e., an Advanced Directive), or giving someone else the right to make healthcare choices for you when you are unable to (Power of Attorney)
e. Privacy. Personal and medical information will only be used or shared as required or allowed by state and federal law
f. Appeal a decision or file a complaint about the plan, and to receive a timely response
g. Free language assistance services when communicating with us
h. Make suggestions regarding our member rights and responsibilities policy

You have the responsibility to:

a. Read this handbook and make sure you understand the Plan. You should call the Health Navigator team if you have any questions
b. Select a PCP and tell us who you have chosen
c. To the extent required by the Plan, seek medical services only from your PCP.
d. Treat all providers and their staff with courtesy and respect
e. Be on time for appointments, and call the office ahead of time if you will be late or need to cancel
f. Get regular health checkups and preventive services
g. Give your provider all the information they need to provide good healthcare to you
h. Participate in making decisions about your medical care and forming a treatment plan
i. Follow plans and instructions for care you have agreed to with your provider
j. Use urgent and emergency services appropriately
k. Show your medical ID card when seeking medical care
l. Tell providers about any other insurance policies that may provide coverage
m. Reimburse us from any third party payments you may receive
n. Provide information we need to properly administer benefits and resolve any issues or concerns that may arise

More information about your rights and responsibilities is below. You may also call the Health Navigator team with any questions.

Will someone tell me if my PCP is no longer participating in the network?
If your PCP ends their participation in the network, we will tell you and give you instructions on how to change your PCP.

What if I have a medical emergency?
If you believe you have a medical emergency, call 911 or seek care from the nearest appropriate provider, such as a physician's office or clinic, urgent care facility or emergency room.

You do not need to contact your PCP before you get emergency treatment. You should contact your PCP as soon as reasonably possible afterward. You are covered anywhere in the world for medical emergency treatment. More information is in section 0.

How will I know if my benefits change or end?
OEBB will notify you if your benefits change or your coverage is terminated. If the policy ends and OEBB does not replace the coverage with another group policy, OEBB is required by law to inform its members in writing of the termination.

What are the prior authorization and utilization review criteria?
Getting prior authorization is your assurance that the services and supplies recommended by your provider are medically necessary and covered under the Plan. You may contact the Health Navigator team or visit your Member Dashboard for a list of services that require prior authorization.

Except in the case of fraud or misrepresentation, prior authorization for benefit coverage and medical necessity is binding for 60 days, and eligibility is binding for 5 business days from the date of the authorization.

Utilization review is the process of reviewing services after they are provided to ensure that they were medically necessary and appropriate with regard to widely accepted standards of good medical practice.

You can get a written summary of information that may be included in our utilization review of a particular condition or disease by calling the Health Navigator team.

What are my rights under the Women's Health and Cancer Rights Act of 1998 (WHCRA)?
You have benefits for mastectomy related services. This includes all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses and complications resulting from a mastectomy, including lymphedema. Contact the Health Navigator team for more information.

How are important documents, such as my medical records, kept confidential?
We protect your information in several ways:

a. We have a written policy to protect the confidentiality of health information
b. Only employees who need to access your information to perform their job functions are allowed to do so
c. Disclosure outside Moda Health is permitted only when necessary to perform functions related to providing coverage and/or when otherwise allowed by law
d. Most documentation is stored securely in electronic files with designated access

If I am not satisfied with the plan, how can I file an appeal or complaint?
You can file an appeal or complaint by writing a letter to Moda Health. The Health Navigator team can help you if needed. Complete information is in section 9.2.

The Health Navigator team can help you if needed. Complete information about the appeal process is in section 9.2.

You may also file a complaint or ask for help from the Oregon Division of Financial Regulation:

Phone: 503-947-7984 or toll-free 888-877-4894
Mail: PO Box 14480, Salem, Oregon 97309-0405
Internet: dfr.oregon.gov
email: dfr.InsuranceHelp@oregon.gov

How can non-English speaking members get information about the Plan?
The Health Navigator team will coordinate the services of an interpreter over the phone when they call.

How can I participate in the development of your corporate policies and practices?
We welcome any suggestions to improve our health benefit plans or services. We have advisory committees to allow participation in the development of corporate policies and to provide feedback. You may contact us for more information.

What is provider risk sharing?
This plan includes risk sharing arrangements with some providers. Under a risk-sharing arrangement, providers are subject to some financial risk or reward for the services they deliver. Contact us for more information.

What additional information about Moda Health is available?
These documents are available free of charge by calling Customer Service:

a. Our annual report on complaints, appeals and prior authorizations
b. Our efforts to monitor and improve the quality of health services
c. Procedures for credentialing network providers and how to obtain the names, qualifications, and titles of the providers responsible for your care
d. Prior authorization and utilization review procedures

The following information about our health benefit plans is available from the Oregon Division of Financial Regulation:

a. The results of all publicly available accreditation surveys
b. A summary of Moda Health's health promotion and disease prevention activities
c. An annual summary of appeals and prior authorizations
d. An annual summary of utilization review policies
e. An annual summary of quality assessment activities
f. An annual summary of scope of network and accessibility of services

Contact:
Oregon Division of Financial Regulation
PO Box 14480, Salem, Oregon 97309-0405
503-947-7984 or toll-free 888-877-4894
dfr.oregon.gov
dfr.InsuranceHelp@oregon.gov

14.2 GENERAL & MISCELLANEOUS PROVISIONS

Contract Provisions
The policy between Moda Health and OEBB and this handbook plus any endorsements or amendments are the entire contract between the parties. No promises, terms, conditions or obligations exist other than those contained in the contract. This handbook and the policy plus any endorsements or amendments shall supersede all other communications, representations or agreements, either verbal or written between the parties. If any term, provision, agreement or condition is held by a court of competent jurisdiction to be invalid or unenforceable, the remainder of the provisions shall remain in full force and effect and shall in no way be affected, impaired or invalidated.

Confidentiality of Member Information
Keeping your protected health information (PHI) confidential is very important to us. PHI includes enrollment, claims, and medical and dental information. We use this information to pay your claims and authorize services. It is also used for referrals, case management and quality management programs. We do not sell your information. The Notice of Privacy Practices has more detail about how we use your PHI. Follow the Privacy Center link on the Moda Health website for a copy of the notice, or call 855-425-4192.

Right to Collect & Release Needed Information
You must give us, or authorize a provider to give us, any information we need to pay benefits. We may release to or collect from any person or organization any needed information about you.

Transfer of Benefits
Only members are entitled to benefits under the Plan. These benefits are not assignable or transferable to anyone else except to the provider.

Correction of Payments or Recovery of Benefits
If Moda Health mistakenly makes a payment for a member to which they are not entitled, or pays a person who is not eligible for payments at all, we have the right to recover the payment from the person paid or anyone else who benefited from it, including a provider. Our right to recovery includes the right to deduct the amount paid from future benefits we would provide for a member even if the mistaken payment was not made on that member's behalf.

If benefits that this Plan should have paid are instead paid by another plan, this Plan may reimburse the other plan. Amounts reimbursed are plan benefits and are treated like other plan benefits in satisfying the Plan's liability.

Warranties
All statements made by OEBB or a member, unless fraudulent, are considered representations and not warranties. No statement made for the purpose of obtaining coverage will void the coverage or reduce benefits unless contained in a written form and signed by OEBB or the member, a copy of which has been given to OEBB or member or the member's beneficiary.

No Waiver
Any waiver of any provision of the Plan or any performance under the Plan must be in writing and signed by the waiving party. Any such waiver shall not operate as, or be deemed to be, a waiver of any prior or future performance or enforcement of that provision or any other provision. If we delay or fail to exercise any right, power or remedy provided in the Plan, including

a delay or omission in denying a claim, that shall not waive Moda Health's rights to enforce the provisions of the Plan.

Group is the Agent
OEBB is the member's agent for all purposes under the Plan. OEBB is not the agent of Moda Health. Moda Health, as administrator of the Plan, is the representative of, and has authority to act for, OEBB under this handbook and the benefit plan document with Moda Health unless and until a member is otherwise notified in writing by OEBB. Where reference in this handbook is made to "the Plan" or to OEBB, such references shall include Moda Health acting in its capacity as administrator of the Plan.

Responsibility for Quality of Medical Care
You always have the right to choose your provider. We are not responsible for the quality of your medical care. Your providers act as independent contractors. We cannot be held liable for any injuries you get while receiving medical services or supplies.

Compliance with Federal & State Mandates
Moda Health provides benefits in accordance with the requirements of all applicable state and federal laws and as described in the Plan. This includes compliance with federal mental health parity requirements.

Governing Law
To the extent the Plan is governed by state law, it shall be governed by and construed in accordance with the laws of the state of Oregon.

Where any Legal Action Must be Filed
Any legal action arising out of the Plan must be filed in either state or federal court in the state of Oregon.

Time Limits for Filing a Lawsuit
Any legal action arising out of, or related to, the Plan and filed against Moda Health by a member or any third party, must be filed in court no more than 3 years after the time the claim was filed (see section 9.1). All internal levels of appeal under the Plan must be exhausted before filing a legal action in court.

Evaluation of New Technology
Moda Health develops medical necessity criteria for new technologies and new use of current technologies. The medical necessity criteria committee reviews information consisting of medical studies, national, regional or local clinical practice guidelines, and local and national carrier benefits to develop the criteria. The reviews are performed once a year, or more often if needed.

Replacing Another Plan
If this Plan replaces an existing policy or a group plan from another insurance company, the following applies:

a. If you are hospitalized on the date this Plan becomes effective, we will reduce this Plan's benefits by an amount paid or payable by your prior plan. This applies until you are discharged from the hospital or the hospital benefits are exhausted, whichever comes first
b. We will credit any deductible amounts you satisfied under your prior plan toward this Plan's deductibles

c. You will give us information we need about the terms of your prior plan and any claim payments your prior plan made

Notices

Any notice to you, to a provider or to the Group that we are required to provide is considered properly given if written notice is deposited in the U.S. mail or with a private carrier. Notices will be addressed to the last known address in our records. If we receive a U.S. Postal Service change of address form, we will update our records with that new address. We may forward a notice for you to the Group if we become aware that we do not have a valid mailing address for you. Any notice you are required to send to us may be mailed to our Customer Service address. Notice to us is not considered given to us and received by us until we have physically received it.

SECTION 15. VALUE-ADDED SERVICES & DISCOUNTS

Membership with Moda Health includes other advantages as well. We give you access to additional services, programs and tools to support your physical, mental and emotional health. When you use these programs, you may receive savings on an item or service that is covered by the Plan. These resources are not part of the Plan, and they are not insurance. Access these extras through your Member Dashboard.

Your enrollment in the Plan automatically gives you access to these programs. Your access to these services ends when your coverage under the Plan ends. We may also discontinue these services for everyone. If we do this, we will notify the Group 30 days in advance.

We may have drawings for gift cards to encourage you to set up accounts from our Moda Health website or other program sites. When an offer is available, we will let you know the details and how to participate.

Behavioral Health 360 Program
The Behavioral Health 360 Program provides personalized help finding the right behavioral health provider for you and ensuring services are meeting your needs. The Behavioral Health 360 Program includes:

a. Access to a Behavioral Health Champion to help you identify the best-fit provider for you.
b. Spring Health's suite of online, virtual, and in-person services.
c. Gemiini's video modeling tools for children with autism spectrum disorder or developmental disability to gain and practice new skills such as speech, daily activity. The tools include coaching and help for parents.
d. Hazelden Betty Ford Foundation's suite of services including coaching for parents, enhanced case management, family member support, and a variety of digital tools related to substance use and recovery.

For more information, contact your Behavioral Health Champion at 833-212-5027.

Birth Doulas Services
A doula can support you before, during and after the birth of your child. Services include:
a. 8 visits (you may want to use some visits before and some after birth)
b. Support services during labor and birth

For members who live in Oregon:
Doulas must be state-certified and DMAP-registered. There is no cost to you unless your doula charges more than the following reimbursement amounts. You may have to pay any charges above that amount. We recommend you discuss pricing with your Birth Doula.
a) Pre-natal and post-natal visits are reimbursed at $215 per visit (up to 8 visits)
b) Birth and Delivery support are reimbursed at $645

Find a doula through the OHA website and select Birth Doula under the Certificate Type drop-down at traditionalhealthworkerregistry.oregon.gov/search. Then ask the doula you want to use if they are DMAP registered. Call 866-923-0409 if you have questions.

For members who live outside of Oregon:

There is no cost to you unless your doula charges more than the following reimbursement amounts. You may have to pay any charges above that amount. We recommend you discuss pricing with your Birth Doula.

a) Pre-natal and post-natal visits are reimbursed at $215 per visit (up to 8 visits)
b) Birth and Delivery support are reimbursed at $645

Out-of-state members must pay for services upfront and submit a reimbursement form. The doula reimbursement form can be found on our website at https://www.modahealth.com/members/forms.shtml. Call 866-923-0409 if you have questions.

Cancer Risk Assessment & Support

Through Gabbi's breast health support program, you can get these services at no cost:

a. Online risk assessment
b. Support through a personalized care plan

Your Gabbi Specialist may refer you to additional services that are covered under your medical plan. You will have to pay the Plan's normal cost sharing if you get those services.

The program is available to you if you are assigned female at birth and are age 18 or older. Sign up for Gabbi through your Member Dashboard, or you can create an account through the Gabbi website at https://www.gabbi.com/moda. If you have questions, contact Gabbi at hello@gabbi.com or call your Moda 360 Health Navigators at (866)-923-0409 (TTY: 711).

Chronic Kidney Disease management

Comprehensive support for chronic kidney disease and end-stage renal disease (ESRD) through Strive Health is available if you qualify. It is free and includes:

a. Access to direct care centers offering disease management and education
b. Phone and virtual visits, including 24 hour access for questions and emergencies
c. Support through wellness checks, disease management, and education
d. Transition planning and support, facility navigation and renal replacement therapy

If you have chronic kidney disease, you will be invited to participate in the program. The invitation will tell you how to get started, or you can call Strive Health at 503-664-9111.

Diabetes Prevention Program

A 12-month program that includes research-based curriculum that starts with weekly group meetings for the first six months, followed by upkeep sessions to keep you on track to meet your goals.

If you have questions or want to learn more about Moda's Pre-D program, email predprogram@modahealth.com or call 833-212-5028.

Diabetes Management Program
Through Teladoc Health's diabetes management program, you can get these things for free:

a. A connected glucose meter, strips, lancing device and lancets
b. Monitoring blood glucose readings
c. Coaching on nutrition and lifestyle questions

Contact Teladoc Health at 800-935-2362 or TeladocHealth.com/Register to access the program.

Gym Membership Through Active&Fit Direct
Through the Active&Fit Direct program, you can get discounted gym memberships. Choose from more than 12,200 locations nationwide. You can change your membership to a different gym at any time. There are also thousands of digital workout videos and digital resources and classes available online.

To participate, you pay a one-time enrollment fee of $28 that is good as long as you continue your enrollment, and an ongoing $28 monthly membership fee. You may call Customer Service at 888-393-2940 for help.

Find out which fitness centers participate with Active&Fit Direct by going to their website through your Member Dashboard. You may call Customer Service at 844-646-2746 for help.

Active&Fit Direct is through American Specialty Health Fitness, Inc., a subsidiary of American Specialty Health Incorporated (ASH). ASH has the right to change any part of the program, including the enrollment or monthly membership fees. ASH will notify you at least 30 days before changing fees. Fitness centers, amenities and classes vary by location, and taxes may apply. Any non-standard services that typically require an additional fee are not included.

Physical Therapy Program
Sword Health is an app-based digital physical therapy program pairs you with a licensed physical therapist (PT) who will customize a program to help you overcome joint, back or muscle pain from home. You get a kit that includes motion trackers and a tablet to give you and your PT real-time feedback. You can chat with your PT anytime, and they will check in, monitor your progress and adjust your program as needed.

The program is free and is available to members who are age 13 and over. Sign up with Sword Health through your Member Dashboard or online at join.swordhealth.com/oebb/register. If you have questions, contact Sword Health at help@swordhealth.com or call 888-492-1860.

Prescription Savings Program

a. Incentive to refill on time:

   If you have diabetes or cardiovascular conditions, the Sempre Health prescription savings program encourages you to refill your prescriptions on time. When you refill your qualifying diabetes and cardiovascular medications as prescribed, you can receive cost sharing discounts through Sempre Health. You will get alerts when it is time to refill your

prescriptions. Your discounts may increase as you continue to refill your prescriptions on time.

If you are prescribed qualifying medications, you will be invited to participate. The invitation will tell you how to get started. It is free to join. Contact Sempre Health at 855-910-0555 if you have questions.

b. Savings on 6-month supply:
Through the 6 for 6 program by Navitus and Costco, you can get a 6-month supply of certain medications for $6 at Costco warehouse retail pharmacies. You do not need a Costco membership to use this program. The list of medications in the program is at: info.navitus.com/6for6. Does not apply to mail order. Call 888-361-1610 if you have questions.

Provider Search Tool
Garner Health Technology, Inc. can be used to help you select an in-network provider. Garner uses data and analytics from several sources to identify doctors that they recommend as being top-performing. When you visit a Garner "Top Provider" for your care, you may be reimbursed* for up to $700 of your cost sharing per year if you have self-only coverage or $1,400 of your family's cost sharing per year if you cover yourself and your family members.

Access Garner through their website at https://www.garnerguide.com/hra-manual/ or by downloading their app. If you need help, call Garner's Concierge team at (458) 488-4828. There is no cost to you to use Garner.

*If you are on high-deductible plan, please review the Garner FAQ at https://www.garnerguide.com/hra-oebb/ for more information about Garner and your Health Savings Account (HSA). Reimbursement provided before you have met your deductible may jeopardize your HSA status with the IRS.

Moda Health does not aid in data collection or provider scoring, and is not responsible for any reimbursement from utilizing Garner to see Garner Top Providers.

Tobacco Cessation Program
Members have access to a tobacco cessation benefit through the Alere Quit-for-life program. Enrollment in the program is covered once per lifetime and a 10-week supply of nicotine replacement therapy (patches or gum) is covered in full.

More information is available at www.modahealth.com/pdfs/oebb/tobacco_cessation.pdf

WW (formerly known as Weight Watchers)
Members can take advantage of OEBB's WW program OEBB in the format that works best for their lifestyle:

a. **Digital** – gives members access to an easy-to-use app that has the tools you need, including food and activity tracking, thousands of recipes, 24/7 Expert Chat with a WW Coach, and so much more.
b. **Digital + Workshops** - gives members access to WW's digital tools, and weekly WW

Workshops in the community or WW Workshops in the workplace (where applicable).

For more information visit: www.OEBBwellness.com

Wellness Products and Services
ChooseHealthy gives you the following health and wellness services at no cost:

a. Discounts on popular health and fitness brands
b. Savings of up to 25% on services from specialty health practitioners including acupuncture, chiropractic and therapeutic massage
c. Access to no-cost online health classes

You may call Customer Service at 877-335-2746 for help. The ChooseHealthy program is provided by ChooseHealthy, Inc., a subsidiary of American Specialty Health Incorporated (ASH).

Virta Health
Virta Health is a virtual clinic for type 2 diabetes reversal and prevention. You can eat your way to better health thanks to personalized food plans and support from medical providers, professional coaches, and digital health tools at no cost. If you are eligible to participate in the program you will receive an invite. Call the Moda 360 Health Navigator at 866-923-0409 for any questions.

Nondiscrimination notice

We follow federal civil rights laws. We do not discriminate based on race, religion, color, national origin, age, disability, gender identity, sex or sexual orientation.

We provide free services to people with disabilities so that they can communicate with us. These include sign language interpreters and other forms of communication.

If your first language is not English, we will give you free interpretation services and/or materials in other languages.

If you need any of the above, call:

888-217-2363 (TDD/TTY 711)

If you think we did not offer these services or discriminated, you can file a written complaint. Please mail or fax it to:

Moda Partners, Inc.
Attention: Appeal Unit
601 SW Second Ave.
Portland, OR 97204
Fax: 503-412-4003

Scott White coordinates our nondiscrimination work:

Scott White,
Compliance Officer
601 SW Second Ave.
Portland, OR 97204
855-232-9111
compliance@modahealth.com

If you need help filing a complaint, please call Customer Service.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights at ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone:

U.S. Department of Health
and Human Services
200 Independence Ave. SW, Room 509F
HHH Building, Washington, DC 20201

800-368-1019, 800-537-7697 (TDD)

You can get Office for Civil Rights complaint forms at hhs.gov/ocr/office/file/index.html.

modahealth.com

Dental plans in Oregon provided by Oregon Dental Service, dba Delta Dental Plan of Oregon. Dental plans in Alaska provided by Delta Dental of Alaska. Delta Dental is a trademark of Delta Dental Plans Association. Health plans provided by Moda Health Plan, Inc. Individual medical plans in Alaska provided by Moda Assurance Company.

ATENCIÓN: Si habla español, hay disponibles servicios de ayuda con el idioma sin costo alguno para usted. Llame al 1-877-605-3229 (TTY: 711).

CHÚ Ý: Nếu bạn nói tiếng Việt, có dịch vụ hỗ trợ ngôn ngữ miễn phí cho bạn. Gọi 1-877-605-3229 (TTY:711)

注意：如果您說中文，可得到免費語言幫助服務。請致電1-877-605-3229（聾啞人專用：711）

주의: 한국어로 무료 언어 지원 서비스를 이용하시려면 다음 연락처로 연락해주시기 바랍니다. 전화 1-877-605-3229 (TTY: 711)

PAUNAWA: Kung nagsasalita ka ng Tagalog, ang mga serbisyong tulong sa wika, ay walang bayad, at magagamit mo. Tumawag sa numerong 1-877-605-3229 (TTY: 711)

تنبيه: إذا كنت تتحدث العربية، فهناك خدمات مساعدة لغوية متاحة لك مجانًا. اتصل برقم 1-877-605-3229 (الهاتف النصي: 711)

توجہ دیں: اگر آپ اردو (URDU) بولتے ہیں تو لسانی اعانت آپ کے لیے بلا معاوضہ دستیاب ہے۔ پر کال کریں 1-877-605-3229 (TTY: 711)

ВНИМАНИЕ! Если Вы говорите по-русски, воспользуйтесь бесплатной языковой поддержкой. Позвоните по тел. 1-877-605-3229 (текстовый телефон: 711).

ATTENTION : si vous êtes locuteurs francophones, le service d'assistance linguistique gratuit est disponible. Appelez au 1-877-605-3229 (TTY : 711)

توجه: در صورتی که به فارسی صحبت می کنید، خدمات ترجمه به صورت رایگان برای شما موجود است. با 1-877-605-3229 (TTY: 711) تماس بگیرید.

ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपको भाषाई सहायता बिना कोई पैसा दिए उपलब्ध है। 1-877-605-3229 पर कॉल करें (TTY: 711)

Achtung: Falls Sie Deutsch sprechen, stehen Ihnen kostenlos Sprachassistenzdienste zur Verfügung. Rufen sie 1-877-605-3229 (TTY: 711)

注意：日本語をご希望の方には、日本語サービスを無料で提供しております。1-877-605-3229（TYY、テレタイプライターをご利用の方は711）までお電話ください。

અગત્યનું: જો તમે (ભાષાંતર કરેલ ભાષા અહીં દર્શાવો) બોલો છો તો તે ભાષામાં તમારે માટે વિના મૂલ્યે સહાય ઉપલબ્ધ છે. 1-877-605-3229 (TTY: 711) પર કૉલ કરો

ໂປດຊາບ: ຖ້າທ່ານເວົ້າພາສາລາວ, ການຊ່ວຍເຫຼືອດ້ານພາສາແມ່ນມີໃຫ້ທ່ານໂດຍບໍ່ເສັຍຄ່າ. ໂທ 1-877-605-3229 (TTY: 711)

УВАГА! Якщо ви говорите українською, для вас доступні безкоштовні консультації рідною мовою. Зателефонуйте 1-877-605-3229 (TTY: 711)

ATENȚIE: Dacă vorbiți limba română, vă punem la dispoziție serviciul de asistență lingvistică în mod gratuit. Sunați la 1-877-605-3229 (TTY 711)

THOV CEEB TOOM: Yog hais tias koj hais lus Hmoob, muaj cov kev pab cuam txhais lus, pub dawb rau koj. Hu rau 1-877-605-3229 (TTY: 711)

ត្រូវចងចាំ៖ បើអ្នកនិយាយភាសាខ្មែរ ហើយត្រូវការសេវាកម្មជំនួយផ្នែកភាសាដោយឥតគិតថ្លៃ គឺមានផ្តល់ជូនលោកអ្នក។ សូមទូរស័ព្ទទៅកាន់លេខ 1-877-605-3229 (TTY: 711)

HUBACHIISA: Yoo afaan Kshtik kan dubbattan ta'e tajaajiloonni gargaarsaa isiniif jira 1-877-605-3229 (TTY:711) tiin bilbilaa.

โปรดทราบ: หากคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือด้านภาษาได้ฟรี โทร 1-877-605-3229 (TTY: 711)

FA'AUTAGIA: Afai e te tautala i le gagana Samoa, o loo avanoa fesoasoani tau gagana mo oe e le totogia. Vala'au i le 1-877-605-3229 (TTY: 711)

IPANGAG: Nu agsasaoka iti Ilocano, sidadaan ti tulong iti lengguahe para kenka nga awan bayadna. Umawag iti 1-877-605-3229 (TTY: 711)

UWAGA: Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń: 1-877-605-3229 (obsługa TTY: 711)

For help, call us directly at 888-217-2363
(En español: 888-786-7461)