2027

Oregon Group Medical Plan

Public Employees' Benefit Board
Moda Coordinated Care Plan
Full-Time
Group# 10002802
January 1, 2027

pebb
Public Employees' Benefit Board

Moda Health Plan, Inc. provides medical claims payment services only
And does not assume financial risk or obligation with respect to payment of claims.

moda HEALTH

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SECTION 1. WELCOME TO MODA HEALTH

The Plan is self-funded and the Group has contracted with Moda Health to provide claims and other administrative services.

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/pebb. You can use it 24 hours a day, 7 days a week to get your plan information whenever it is convenient.

The Group may change or replace this handbook at any time, without your agreement. You can find the most current handbook on your member website, Member Dashboard. All plan provisions are governed by the Group's agreement with Moda Health. 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.

SECTION 2. MEMBER RESOURCES

2.1 CONTACT INFORMATION

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

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

- Find an in-network provider with Find Care
- See if a service or supply you need must be prior authorized first www.modahealth.com/medical/referrals

Medical Health Navigator Customer Service Department
844-776-1593
En español 888-786-7461

Behavioral Health Customer Service Department
833-212-5027

Disease Management and Health Coaching
800-592-8283

Prescription Drug Plan (administered by Judi Rx)
833-895-9846
https://enrollment.cap-rx.com/?client=oregonpebb

Virtual Care preferred vendor
CirrusMD
Modahealth.com/cirrusmd

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

Telecommunications Relay Service for the hearing impaired
711

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

Public Employee's Benefit Board (PEBB)
503-373-1102

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 Customer Service.

2.3 NETWORKS

Network Information (Section 5) explains how networks work. These are the networks for your Plan.

Medical network
Connexus

Out-of-Area network
Aetna® PPO Network through Aetna Signature Administrators®

2.4 CARE COORDINATION & WELLNESS

Your enrollment in the Plan gives 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.

2.4.1 Care Coordination

Our care coordinators work directly with providers to facilitate prior authorization of scheduled procedures, inpatient stays and follow-up care as needed during your urgent or emergent admissions. 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.

You can self-refer to case management or be referred by a family member, caregiver, provider or facility staff. Contact Moda Healthcare Services case management:

a. Phone: 503-948-5561 or toll-free at 800-592-8283
b. email: casemgmtrefer@modahealth.com
c. Fax: 503-243-5105
d. Online through your Member Dashboard: Submit a referral form (available at www.modahealth.com/pdfs/referral_form_case_mgt.pdf)

Include the information:

a. Your name and ID number (this can be found on your Moda Health ID card)
b. Contact name and number
c. Reason for the referral

Once we receive a referral, a case manager will evaluate your situation and contact you within 5 business days.

Additional information regarding case management and care coordination services is available at your Member Dashboard under Healthcare coordination.

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.

The care programs include:

a. Cardiac Care
b. Dental Care
c. Depression Care
d. Diabetes Care
e. Lifestyle Coaching
f. Respiratory Care
g. Spine & Joint Care
h. Women's Health & Maternity Care

You can learn more about Moda Health's disease management care programs at your Member Dashboard, by calling 503-948-5561 or toll-free at 800-592-8283, or by email at careprograms@modahealth.com.

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. You also have access to Spring Health's online, virtual and in-person behavioral health services. Behavioral Health Customer Service can help you find in-network providers and understand your mental health and substance use disorder benefits.

2.4.4 Behavioral Health 360 Program

Moda Health's Behavioral Health 360 Program is a combination of personalized services to help you meet your behavioral health needs. It includes:

a. Access to a Behavioral Health Champion who can help you find the right provider for you
b. The Spring Health platform, including access to Spring Health therapists and psychiatric providers
c. Gemiini's video modeling tools for children with autism spectrum disorder or developmental disability, to gain and practice new skills such as speech and daily activity. The tools include coaching and help for parents
d. Hazelden Betty Ford Foundation's substance use and recovery services including coaching for parents, enhanced case management, family member support and digital tools

Access the program through your Member Dashboard, or contact your Behavioral Health Champion at 833-212-5027.

2.4.4.1 WW (formerly known as Weight Watchers) Program

You can take advantage of PEBB's WW program in the format that works best for your lifestyle:

a. **Digital** –an app with tools including food and activity tracking, thousands of recipes, 24/7 Expert Chat with a WW Coach and so much more.
b. **Digital + Workshops** - WW's digital tools plus weekly WW Workshops in the community or WW Workshops in the workplace (where available).

For more information visit: https://www.oregon.gov/oha/PEBB/Pages/WW-Experience.aspx

2.4.4.2 Virta Health

Virta Health is a virtual clinic for type 2 diabetes reversal and prevention. Members can eat their way to better health thanks to personalized food plans and support from medical providers, professional coaches, and digital health tools at no cost. Members who are eligible to participate in the program will receive an invite.

Call the Moda 360 Health Navigator at 844-776-1593 for any questions.

2.4.4.3 Garner Health Technology Provider Search Tool

Garner is a tool that helps you find high-quality care. When you choose to visit a Garner-approved Top Provider, you can be reimbursed* for the costs you pay for your visit. This includes your deductible, copay or coinsurance. It also includes other services like labs, prescriptions and x-rays when they're ordered by your Top Provider.

*You may be reimbursed up to:

a. $1,250 of your cost sharing per year, if you have individual coverage.
b. $2,500 of your family's cost sharing per year, if you cover yourself and family members.

Garner is especially useful when looking for specialists or a new provider.
To get started finding a Top Provider:

a. Go to app.getgarner.com
b. Use the Garner Health app
c. Call 458-488-4828

If you have an FSA? you can not be reimbursed for the cost of your visit by both Garner and your FSA. IRS rules for tax-advantaged plans do not allow this.

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

2.5 OTHER RESOURCES

You can find other general information about the Plan in Section 13.

Membership with Moda Health includes other advantages as well. You have access to 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. You can access these extras through your Member Dashboard.

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 12.

Cost sharing is the amount you pay. See Section 4 for more information, including an explanation of deductible, out-of-pocket maximum, and maximum cost share. If you do not use an in-network provider, you may have to pay any amount that is over the maximum plan allowance.

When a benefit has an "annual" or "per year" limit, it will accrue on a calendar year basis unless otherwise specified.

	In-Network Benefits	Out-of-Network Benefits
Annual deductible per Member	**$500**	**$500**
Maximum annual deductible per family	**$1,500**	**$1,500**
Annual Out-of-Pocket Maximum per Member	**$1,500**	**$4,000**
Annual Out-of-Pocket Maximum per Family	**$4,500**	**$12,000**
Pharmacy (Administered through Judi Rx)		
Annual Deductible per Member	**$50**	
Maximum Annual Deductible per Family	**$150**	
Annual Out-of-Pocket Maximum per Member	**$1,000**	
Annual Out-of-Pocket Maximum per Family	**$3,000**	

Services	Amount You Pay Deductible applies unless noted differently		Section in Handbook & Details
	In-Network	Out-of-Network	
Urgent & Emergency Care			
Ambulance Transportation	$75 per trip	$75 per trip	Section 7.3.1
Emergency Room Facility (includes ancillary services)	$150 per visit*	$150 per visit* In-network deductibles and maximum cost sharing apply	Section 7.3.2 Hospital inpatient Care copay applies instead if admitted to hospital from emergency room Professional and ancillary services billed separately are subject to standard cost sharing per service
Urgent Care Office Visit	$25 per visit	$25 per visit	Section 7.3.4
Preventive Services			
Services as required under the Affordable Care Act, including:			Section 7.4
Colonoscopy	No cost sharing	30%	Section 7.4.1 One per 10 years, age 45+ Related charges included
Contraception	No cost sharing	30%	Section 7.4.2
Immunizations	No cost sharing	30%	Section 7.4.3
Mammogram	No cost sharing	30%	Section 7.4.8 One per year, age 40+
Pediatric Screenings	No cost sharing	30%	Section 7.4.4 Age and frequency limits apply
Preventive Health Exams (by primary care provider only)	No cost sharing	30%	Section 7.4.5 6 visits in first year of life 7 exams from age 1 to 4 One per year, age 5+
Tobacco Cessation Treatment			Section 7.4.7
Consultation	No cost sharing	Not covered	Frequency limits may apply
Supplies	No cost sharing	15%	
Women's Exam & Pap Test	No cost sharing	30%	Section 7.4.8 One per year

Services	Amount You Pay Deductible applies unless noted differently		Section in Handbook & Details
	In-Network	Out-of-Network	
Other preventive services, including:			
Screening X-ray & Lab	No cost sharing	30%	Section 7.5.12 Once per year, age 50+
Prostate Rectal Exam	No cost sharing	30%	Section 7.4.6 Once per year, age 50+
Prostate Specific Antigen (PSA) Test	No cost sharing	30%	
General Treatment Services			
Acupuncture	$10 per visit*	30%**	Section 7.5.1 12 visits per year
Anticancer Medication			Section 7.5.2
Injectable Medications	$25per visit	30%	
Applied Behavior Analysis	$10 per service, no deductible	30%	Section 7.5.3
Bariatric Surgery Facility	$50 per day/$250 per admission	Not covered	Section 7.5.4 Also see Additional Cost Tier below
Behavioral Health Services			Section 7.5.5
Detoxification (Detox)	No cost sharing	40%	
Office Visits			
Mental Health	$10 per service, no deductible	30%	
Substance Use Disorder	No cost sharing	30%	
Intensive Outpatient			
Mental Health	$10 per service, no deductible	30%	
Substance Use Disorder	No cost sharing	30%	
Other Outpatient Services			
Mental Health	$10 per service, no deductible	30%	
Substance Use Disorder	No cost sharing	30%	
Coordinated Specialty Programs	No cost sharing	30%	
Inpatient			
Mental Health	$50 per day/ $250 per admission	$500 per admission then 40%	
Substance Use Disorder	No cost sharing	40%	

Services	Amount You Pay Deductible applies unless noted differently		Section in Handbook & Details
	In-Network	Out-of-Network	
Partial Hospitalization			Section 7.5.5
Mental Health	$50 per day/ $250 per admission	40%	
Substance Use Disorder	No cost sharing	40%	
Residential Treatment Program			
Mental Health	$50 per day/ $250 per admission	40%	
Substance Use Disorder	No cost sharing	40%	
Biofeedback	$25 per visit	30%	Section 7.5.6 10 visits lifetime maximum
Dental Injury	$25 per procedure	30%	Section 7.5.10
Diabetes Services	No cost sharing	30%	Section 7.5.11 Diabetes self-management program covered once, following diagnosis
Diabetic Supplies and Insulin	No cost sharing	No cost sharing	Section 7.5.14 Supplies covered under DME benefits
Insulin Pumps	No cost sharing	No cost sharing	Section 7.5.14 Supplies covered under DME benefits
Diagnostic Procedures, including x-ray and lab	No cost sharing	30%	Section 7.5.12
Advanced Imaging	$100 per service	$100 per service, then 30%	Section 7.5.12 Copay does not apply to services related to cancer diagnosis and treatment
Disease Management for Pain	No cost sharing	30%	Section 7.5.13
Durable Medical Equipment (DME) Supplies & Appliances	15%	30%	Section 7.5.14
Disposable Supplies (provided in a professional provider's office)	15%	30%	Section 7.5.14

Services	Amount You Pay Deductible applies unless noted differently		Section in Handbook & Details
	In-Network	**Out-of-Network**	
Hearing Aids & Related Services	10%, no deductible**	10%, no deductible**	Section 7.5.17 Once every 3 years
Hearing Exams	$25 per visit, no deductible*	30%, no deductible**	Section 7.5.17 Once every year
Home Healthcare	$25 per visit	30%	Section 7.5.18 180 visits per year
Hospice Care			Section 7.5.19
Home Care	No cost sharing	No cost sharing	
Inpatient Care	No cost sharing	No cost sharing	
Respite Care	No cost sharing	No cost sharing	
Hospital Inpatient Care	$50 per day/ $250 per admission	$500* per admission then 40%	Section 7.5.20
Hospital Physician Visits	No cost sharing	30%	Section 7.5.21
Infusion Therapy			Section 7.5.23 Some medications may be limited to certain providers or settings, or covered separately under the pharmacy plan
Home Infusion	No cost sharing	30%	
Outpatient Infusion	$25 per visit	30%	
Kidney Dialysis	$25 per service	30%	Section 7.5.24
Massage Therapy	$10 per visit*	30%**	Section 7.5.25 $1,000 annual maximum
Nutritional Therapy	No cost sharing for first 2 visits, then $25 per visit, no deductible	30%	Section 7.5.29
Preventive (as required under Affordable Care Act)	No cost sharing	30%	
Observation Care	$50 per day/ $250 per admission	$500 per admission then 40%	

Services	Amount You Pay Deductible applies unless noted differently		Section in Handbook & Details
	In-Network	Out-of-Network	
Office Visits			
Primary Care Providers	$10 per visit (First 4 visits, no deductible)	30%	Section 7.5.30 In-network only applies when you use a PCP 360 See also Virtual Care Visits
Specialists	$25 per visit	30%	Section 7.5.30
Naturopaths, Chiropractors, Massage Therapists and Acupuncturists	$10 per visit*	30%**	Section 7.5.30
Chronic Conditions	No cost sharing	30%	Section 7.5.30 Chronic conditions: asthma, diabetes, heart conditions
Rehabilitation & Habilitation (Physical, occupational and speech therapy)			Section 7.5.33 Rehabilitation up to 60 outpatient sessions and 30 inpatient days per year. Up to 60 sessions or days for head or spinal cord injury. Habilitation only covered for outpatient, mental health conditions
Outpatient	$25 per visit	30%	
Cardiac Rehabilitation	$25 per service	30%	
Inpatient	$50 per day/$250 per admission	40%	
Skilled Nursing Facility Care	$50 per day/ $250 per admission	40%	Section 7.5.34 180 days per year
Spinal Manipulation	$10 per visit*	30%**	Section 7.5.35 20 visits per year
Surgery Procedures			Section 7.5.36
Outpatient Surgery Professional Charges	$25 per service	30%	
Outpatient Surgery Facility	$25 per service	$100 per service, then 40%	
Inpatient	No cost sharing	30%	
Temporomandibular Joint Syndrome (TMJ)	$25 per service	Not covered	Section **7.5.37** Related physical therapy limited to 20 visits per year
Therapeutic Injections	$25 per service	30%	Section 7.5.38
Allergy Shots, Serums	$25 per service	30%	
Therapeutic X-ray	$25 per service	30%	Section 7.5.39

Services	Amount You Pay Deductible applies unless noted differently		Section in Handbook & Details
	In-Network	**Out-of-Network**	
Transplants			Section 7.5.40 Only covered at an approved Center of Excellence facility
Facility charges	$50 per day/ $250 per admission	N/A	
Professional Charges	$25 per visit	N/A	
Virtual Visits			Section 7.5.42
Through CirrusMD	No cost sharing	N/A	Log on via modahealth.com/cirrusmd
Other providers	No cost sharing	30%	For primary care visits only
Additional Cost Tier			
Bunionectomy	$100 per procedure*	$100 per procedure*, then 30%	Section 4.1 Does not include services related to cancer diagnosis or treatment for traumatic injury
Hammertoe surgery	$100 per procedure*	$100 per procedure*, then 30%	
Morton's neuroma	$100 per procedure*	$100 per procedure*, then 30%	
Spinal injections for pain	$100 per procedure*	$100 per procedure*, then 30%	
Upper gastrointestinal endoscopy	$100 per procedure*	$100 per procedure*, then 30%	
Knee arthroscopy	$500 per procedure*	$500 per procedure*, then 30%	
Knee, hip replacement	$500 per procedure*	$500 per procedure*, then 30%	
Knee, hip resurfacing	$500 per procedure*	$500 per procedure*, then 30%	
Shoulder arthroscopy	$500 per procedure*	$500 per procedure*, then 30%	

Services	Amount You Pay Deductible applies unless noted differently		Section in Handbook & Details
	In-Network	Out-of-Network	
Sinus surgery	$500 per procedure*	$500 per procedure*, then 30%	
Spine procedures	$500 per procedure*	$500 per procedure*, then 30%	
Bariatric surgery	$500 per procedure*	Not covered	Also see Section 7.5.4
Maternity Services			
Breastfeeding			Section 7.6.2
Support and Counseling	No cost sharing	30%	
Breast Pump and Supplies	No cost sharing	No cost sharing	
Fertility services	No cost sharing	N/A	Section 7.6.8 Only covered through Progyny program Limited to 1 Progyny Smart Cycle
Maternity			Section 7.6
Office Visits	No cost sharing	30%	
Diagnostic Services	No cost sharing	30%	
Other Outpatient and Surgical Procedures	No cost sharing	30%	
Facility Charges	$50 per day/$250 per admission	$500 per admission then 40%	
Labor and Delivery	No cost sharing	30%	
Newborn Nursery Care	First visit covered at no cost sharing, then $50 per day/$250 per admission	$500 per admission then 40%	Section 7.6.8
Doula Supportive Services (pre- and post-natal, labor and delivery)	No cost sharing	No cost sharing	Section 7.6.8 $3,760 annual maximum

Services	Amount You Pay Deductible applies unless noted differently		Section in Handbook & Details
	In-Network	**Out-of-Network**	
Prescription Medication	Covered through Judi Rx		Logon via https://app.cap-rx.com/login
Pharmacy			
Prescription Medications			Section **Error! Reference source not found.**
Retail Pharmacy			Up to 30-day supply per prescription, and up to 90-day supply at participating retail pharmacies***
Value Tier	No cost sharing	No cost sharing	
Generic Tier	$10	$10	
Brand Tier	$30	$30	
Mail Order Pharmacy			90-day supply per prescription
Value Tier	No cost sharing	N/A	
Generic Tier	$25	N/A	
Brand Tier	$75	N/A	
Specialty Pharmacy			Up to 30-day supply per prescription for most medications****
Generic Tier	$10	N/A	
Brand Tier	$100	N/A	

* Copayment does not apply to the medical out-of-pocket maximums.
** Coinsurance does not apply to the medical out-of-pocket maximums.
***The copay for a 90-day supply at participating retail pharmacies would be 2.5 times the copay for the 30-day supply.
**** When allowed, the copay for a specialty pharmacy 90-day supply is 2.5 times the copay for a 30-day supply.

SECTION 4. PAYMENT & COST SHARING

4.1 ADDITIONAL COST TIER

Some surgical procedures have less invasive options. When you get these procedures, you will have to pay a copayment in addition to the standard cost sharing. Additional cost tier procedures include the following:

$100 cost tier:

a. Bunionectomy
b. Hammertoe surgery
c. Morton's Neuroma
d. Spinal injections for pain
e. Upper gastrointestinal endoscopy

$500 cost tier:

a. Arthroscopy (knee and shoulder)
b. Hip replacement
c. Knee replacement
d. Knee/hip replacement
e. Spine surgery
f. Bariatric Surgery
g. Uncomplicated hernia repair

Some Additional Cost Tier services must be prior authorized (see Section 6). A full list of services that must be prior authorized is on the Moda Health website. More information is on your Member Dashboard, or ask Customer Service for more information about the additional cost tier. Also see Sections 7.5.36 for imaging and surgery benefits generally.

4.2 DEDUCTIBLES

Every year, you 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 all 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. The deductible amounts, and the amount you pay after the deductible is met, are shown in Section 3. In-network and out-of-network services have separate deductibles. If more than one member of your family is covered, you only have to pay your per member deductible until the total family deductible is reached. Copayments and disallowed charges do not count toward your annual deductible

If the Group has changed coverage to a health benefit plan with Moda Health, we will credit any deductible you met under your old plan during the year to your new Moda Health Plan.

Your deductible is added up on a calendar year basis. If the Plan renews on a date other than January 1st, you may have to meet some additional deductible after renewal through December 31st.

4.3 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 for the rest of the year. If more than one member of your family is covered, the per member maximum applies only until the total family out-of-pocket maximum is reached, even if no single family member has reached the per member maximum. In-network and out-of-network out-of-pocket maximums add up separately and are not combined.

The Plan has a separate out-of-pocket maximum for pharmacy expenses (See Judi Rx benefit summary for pharmacy benefits).

Out-of-pocket costs are added up on a calendar year basis. If the Plan renews on a date other than January 1st, you may have to pay more out-of-pocket costs after renewal through December 31st.

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

a. Medical and pharmacy deductibles
b. Office visits to naturopaths, chiropractors, massage therapists and acupuncturists
c. Emergency Services
d. Imaging Services
e. Fertility services
f. Hearing exams and hearing aids
g. Sleep studies
h. Spinal manipulation, massage therapy and acupuncture
i. Additional cost tier services
j. Non-essential health benefits
k. Disallowed charges

4.4 ANNUAL MAXIMUMS

The Plan helps protect you from very high medical costs in 2 ways: the maximum out-of-pocket and the maximum cost share. These are 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 most covered charges for the rest of the year.

If more than one member of your family is covered, the per member maximums apply only until the total family maximums are reached, even if no single family member has reached the per member maximum. In-network and out-of-network out-of-pocket maximums add up separately and are not combined. The in-network out-of-pocket maximum does count toward the maximum EHB cost share. The Plan has separate out-of-pocket maximums for pharmacy expenses (See the Judi Rx benefit summary for pharmacy benefits).

After the per member or per family maximum cost sharing is met, the Plan will pay 100% of covered in-network services for the rest of the plan year. If coverage is for more than one member, the per member maximum applies only until the total family maximum cost share is reached.

There are some charges you will always have to pay. They do not count toward either maximum:

a. Massage therapy
b. Disallowed charges

Disallowed charges include things such as charges over maximum dollar or visit limits or the maximum plan allowance (MPA), penalties and premium payments.

Costs for the annual maximums are added up on a calendar year basis. If the Plan renews on a date other than January 1st, you may have to pay more out-of-pocket and EHB costs after renewal through December 31st.

Maximum Out-of-Pocket
Most covered expenses count toward your maximum out-of-pocket. The following costs do not. You will still have to pay them, even after your maximum out-of-pocket is met:

a. Deductibles
b. Emergency services
c. Advanced imaging
d. Fertility services
e. Hearing exams and hearing aids
f. Sleep studies
g. Spinal manipulation, massage therapy and acupuncture, including the office visits
h. Additional cost tier services
i. Disallowed charges

Maximum Cost Share
The maximum cost share is the annual limit on in-network cost sharing for essential health benefits (EHB). Essential health benefits are:

a. Ambulatory services
b. Emergency services
c. Hospitalization
d. Maternity and newborn care
e. Mental health and substance use disorder service
f. Rehabilitative and habilitative services and devices
g. Laboratory tests
h. Preventive and wellness services and chronic disease management
i. Pediatric oral and vision care
j. Pharmacy expenses (these are credited to your maximum cost share from your Pharmacy Plan)

Your in-network out-of-pocket maximum will also be credited toward your maximum cost share.

The following costs do not count toward your maximum cost share. You will always have to pay them, even after the maximum cost share is met:

a. Services that do not qualify as essential health benefits
b. Massage therapy
c. Services from out-of-network providers (these services may count toward your out-of-pocket maximum, see section 4.3)
d. Extra expenses you pay when you use a brand medication when a generic is available
e. Disallowed charges

4.5 PAYMENT

The Plan is self-funded. This means money that pays your claims comes from the Group. Moda Health provides claims and other administrative services. Where this book talks about Moda Health paying claims, it means that we are issuing benefits that the Group is providing (paying).

Covered expenses are paid based on the maximum plan allowance (MPA). The MPA is defined in Section 12. You may have to pay some of the charges (cost sharing). What you have to pay depends on the Plan provisions.

Except for cost sharing and Plan benefit limitations, in-network providers agree to look only to the Plan for compensation of covered services provided to members under the Plan.

4.6 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 a PCP 360, you will receive quality healthcare and will have a higher level of benefits. Use Find Care on your Member Dashboard to use an in-network provider. You may contact Customer Service if you need help. Your member ID card will list your network.

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). This is called balance billing. Remember to ask providers to send any lab work or x-rays to an in-network facility.

When you use an out-of-network provider, you will get out-of-network benefits for those services. See section 5.2 for more information.

5.1 General Network Information

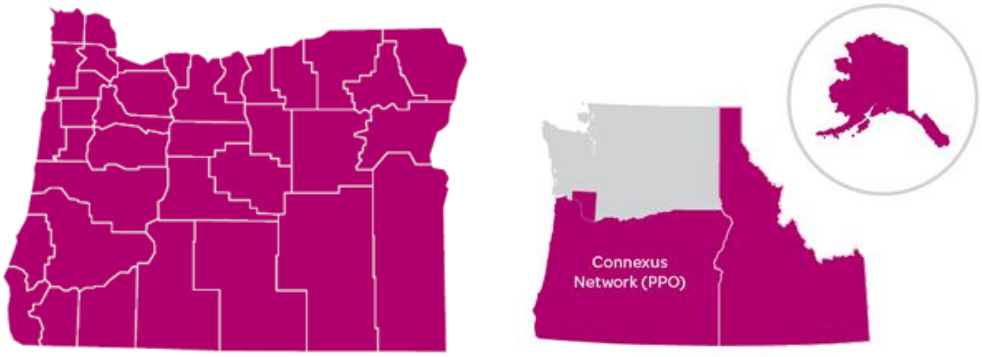
5.1.1 Network and Service Area

Your network provides services in your service area. Subscribers must live or work in Oregon and bordering counties. If you move outside of your network service area, you must contact Customer Service to find out if another network is available, so you 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 accept Moda insurance, but not be participating with the network for your Plan. Contact Customer Service if you need help finding an in-network provider.

Networks

Medical network is Connexus, with providers in Oregon, southwest Washington, Idaho and Alaska



Out-of-Area network is Aetna® PPO

5.1.2 Out-of-Network Care

When you use 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 7.3) 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. 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 MODEL & PCP 360

Your Plan is designed to help you make appropriate healthcare decisions by encouraging you to work with a PCP 360. A PCP 360 is a healthcare clinic or professional provider that specializes in family practice, general practice, internal medicine or pediatrics, and has been recognized for their commitment to patient centered care.

The PCP 360 will coordinate your medical care and arrange for care from specialists and prior authorizations. These providers have an on-call system to provide 24-hour service. If you need to contact your PCP 360 after normal office hours, call the regular office number.

Members on this plan must use a PCP 360 for primary care to receive in-network benefits. If you receive services from a primary care provider that is not a PCP 360 you will pay out of network cost-sharing.

5.2.1 How to select a PCP 360

Each member of your family may use a different PCP 360. A directory of in-network PCP 360 can be found on:

a. Your Member Dashboard under Find Care
b. Contact the Health Navigator team for help.

Contact the PCP 360 to make sure they are accepting new patients.

Select or change your PCP 360 on your Member Dashboard or by contacting the Health Navigator team.

5.2.2 PCP 360

Your PCP 360 is the first provider you should go to for advice about medical care, unless it is an emergency.

Your PCP 360 will provide and/or coordinate all of your healthcare needs.

5.2.3 Other In-Network Primary Provider Care

You may use any in-network provider, but all care should be coordinated by your PCP 360. You must use a PCP 360 for primary care to receive in-network benefits. If you receive services from a primary care provider that is not a PCP 360 you will pay out of network cost sharing except:

You may see an in-network women's healthcare provider for preventive women's health exams and other gynecological care, and for pregnancy care, even if they are not part of your PCP 360 group. A women's healthcare provider is an in-network:

a. Obstetrician or gynecologist
b. Physician associate, advanced registered nurse practitioner or naturopathic physician specializing in women's health'
c. Certified nurse midwife, practicing within their lawful scope of practice

To select a women's healthcare provider as your PCP 360, they must meet certain standards and must have requested designation from us as a PCP 360.

5.2.4 Out-of-Network Provider Care

We work with your PCP 360s to encourage them to refer you to in-network providers whenever possible. These providers have agreed to cooperate in our quality assurance and utilization review programs. Make sure a provider you have been referred to is in-network. Do this by using Find Care on your Member Dashboard. When you use healthcare providers that are not in-network, your benefits are at the lower, out-of-network level shown in 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.

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 at modahealth.com/pebb 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 Providers

To use this Plan, you must use a PCP 360, where you will access primary care. To find a PCP:

a. Enter ZIP code, City or State and select primary care tile
b. Select applicable sub-specialty tile (i.e. family medicine) then use the 'more filter' button to select PCP 360

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

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 advanced imaging 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 who perform advanced imaging services 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 services are not authorized in advance, the Plan will not pay any benefits if the service does not meet our criteria for being medically necessary. When you use an out-of-network provider, you are responsible for making sure that your provider contacts us for prior authorization. If we find that the service is not medically necessary and your provider is out-of-network, you will have to pay the full charge. In-network providers will get prior authorization for you. If your in-network provider does not get prior authorization when required, they must write off the full charge of the service.

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. Musculoskeletal services
e. Diagnostic services, including imaging services
f. Infusion therapy
g. Coordinated specialty programs
h. Disease management for pain
i. Medications

For advance imaging and musculoskeletal services, you may also have to use a preferred procedure site. Your provider must submit documentation attesting medical necessity for higher acuity care settings when a 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 Customer Service. 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 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 not pay anything 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 12.

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 YOUR RESPONSIBILITY IN THE PLAN

You are responsible for:

a. Using a PCP 360 who is in your network
b. Actively working with your PCP 360 and any other professional provider treating you to make sure all your care is being provided in-network. You may have to pay some or all of the charges for care you get from out-of-network providers

7.2 WHEN BENEFITS ARE AVAILABLE

The Plan only pays 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. Your premiums are paid 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.

Care you get outside of the United States is only covered for an urgent care or emergency medical condition.

7.3 URGENT & EMERGENCY CARE

Emergency services and urgent care are covered. Emergency services are covered at the in-network benefit level.

Care received outside of the United States is only covered for an urgent care or emergency medical condition. If you get emergency care outside the United States, you will have to pay for those services at that time and send a claim to us as described in Section 9.1.1.

7.3.1 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.

7.3.2 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 the emergency room physician or 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 12) 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, you cannot be balance billed unless permitted by law.

If you are admitted to the hospital immediately after emergency services, you will not have to pay the emergency room facility copayment. You will still need to pay any cost sharing for the hospital and other charges.

Prior authorization is not needed for emergency medical screening exams or treatment to stabilize an emergency medical condition. Let your PCP 360 know as soon as possible about any emergency care that you receive.

7.3.3 Emergencies & Urgent Care Outside the Service Area

If you are outside of the service area when you have a medical emergency, seek medical attention from the nearest appropriate facility or call 911. Let your PCP 360 know about any emergency care you receive within 24 hours, or as soon as possible. You must get a referral from your PCP 360 for any follow-up care. If you do not, the follow-up care will be paid at the out-of-network benefit level.

If you must be admitted to an out-of-network facility, your PCP 360 and Moda Health's medical director 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 we have approved your PCP 360's prior authorization request. We will not approve unless the service is not available in your network. These are some examples of services that are not 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.

7.3.4 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 or immediate care facility is covered. You must be actually examined by a professional provider.

7.4 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 June 30, 2025
b. Immunizations recommended by the Advisory Committee on Immunization Practices of the Center for Disease Control and Prevention (ACIP) (www.cdc.gov/acip-recs/hcp/vaccine-specific/?CDC_AAref_Val=https://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 June 30, 2025

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 to you.

The Moda Health website has a list of preventive services covered at no cost sharing as required by the ACA or recommended by other organizations we use that provide scientific evidence-based recommendations for preventive care (such as the West Coast Health Alliance (WCHA) and other professional organizations). You may also call Customer Service to find out if a preventive service is on this list. Other preventive services may have member cost sharing when not prohibited by federal law. Some commonly used preventive services covered by the Plan are:

7.4.1 Colorectal Cancer Screening

One of the following services, including related charges such as consultations and pre-surgical exams, if you are age 45 or over:

a. Fecal occult blood test (FOBT) or fecal immunochemical test (FIT) every year
b. Fecal DNA test every 3 years
c. CT colonography, flexible sigmoidoscopy or double contrast barium enema every 5 years
d. Flexible sigmoidoscopy every 10 years plus FIT every year
e. Colonoscopy, including polyp removal every 10 years

With the exception of colonoscopy, screening tests involve 2 steps. If you have a positive result on a USPSTF-recommended screening covered under the preventive benefit, one follow-up colonoscopy to confirm the result of the original screening will also be covered under the preventive benefit as part of the screening procedure.

Anesthesia for colorectal cancer screening is covered under the preventive benefit. Anesthesia for your colonoscopy under the preventive benefit does not need prior authorization. All other anesthesia for colorectal cancer screening must be prior authorized.

These screening timelines apply to you if you are not at high risk for colorectal cancer. You may be screened earlier or more often if it is medically necessary. You are high risk if you have a family medical history of known genetic disorders that predispose you to a high lifetime risk of colorectal cancer (such as Lynch syndrome), you have had colorectal cancer or an adenomatous polyp before, or you have had inflammatory bowel disease Screening exams and laboratory tests, including a follow-up colonoscopy to check progress of the original findings, are paid at the medical benefit level if you do not meet the criteria for the USPSTF A or B rated recommendation.

7.4.2 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 Customer Service for help. We may prior authorize services at no cost to you 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. 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.

7.4.3 Immunizations

Routine immunizations are limited to those recommended by the ACIP or other organizations we use that provide scientific evidence-based recommendations for immunizations (such as the West Coast Health Alliance (WCHA) and other professional organizations). 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.

7.4.4 Pediatric Screenings

At the frequency and age recommended by HRSA or USPSTF, including:

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

7.4.5 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 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 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.

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

If you are age 50 or over one rectal exam and one PSA test is covered every year. If you are at high risk for prostate cancer, a prostate rectal exam and PSA test are covered earlier or more often if your professional provider recommends it.

7.4.7 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.

7.4.8 Women's Healthcare

Preventive women's healthcare visits, including one pelvic and breast exam and one Pap test each year.

Pap tests, and other 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. They are covered under the office visit or lab test benefit level if they are not within the Plan's age, frequency or other limits for preventive screening.

You may see a women's healthcare provider instead of your PCP 360 for preventive women's health exams and related follow-up visits or treatment including x-rays, laboratory tests or surgery. The women's healthcare provider should keep the PCP 360 informed of the medical care they are giving you.

Breast Exams:
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 year age 40 and older.

Supplemental breast exams will also be covered under the preventive benefit:

a. To confirm results of the original screening, using MRI, ultrasound or mammogram
b. When you are high risk, using MRI or ultrasound

Cervical Cancer Screenings:
Cervical cancer screenings and follow-up exams are covered under the preventive benefit. A follow-up exam is additional testing to confirm results of an abnormal pap screening to evaluate for potential cancer.

Any services after you are diagnosed with cervical cancer are covered under the medical benefit.

7.5 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.

7.5.1 Acupuncture
A limited number of visits are covered each year. 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.

7.5.2 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. 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 Customer Service.

7.5.3 Applied Behavior Analysis (ABA)
Applied behavior analysis (ABA) is a type of treatment for individuals with autism spectrum disorder (formerly called pervasive developmental 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.

Applied behavior analysis does not include psychological testing, neuropsychology, psychotherapy, cognitive therapy, sex therapy, psychoanalysis, hypnotherapy or long term counseling.

Examples of what we do not cover:

a. Services provided by your family or household members
b. Custodial or respite care, horse-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, except this Plan if it is your employee benefit plan offered by the Department or the Authority

7.5.4 Bariatric Surgery
In-network medically necessary bariatric surgery services, limited to gastric bypass, gastric stapling, gastroplasty, gastric sleeve, and the Lap-Band adjustable gastric banding system, are covered if you meet the clinical criteria, including all of the following requirements:

a. Have a body mass index (BMI) equal to or greater than:
    i. 35 with a diagnosis of diabetes
    ii. 40 with any obesity related comorbid condition such as obstructive sleep apnea, treated hypertension, treated diabetes or cardiac disease
    iii. 50 with or without obesity related comorbid conditions
b. Complete a 6-month work up that includes dietary counseling and education, medical and psychological evaluation and a weight loss of greater than 5% during the work up period
c. Prior authorize and obtain approval after the 6-month work up period
d. Services must be received at a Center of Excellence facility that

i. Moda Health has arranged or contracted with to provide bariatric surgery and
ii. meets the Health Evidence Review Commission guidelines for facilities providing bariatric surgery

7.5.5 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 must be prior authorized. Coordinated specialty programs must be prior authorized or authorized as soon as reasonably possible after you start them. See Section 7.5.12 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.

If you cannot find an in-network provider, contact Behavioral Health Customer Service and ask to speak with a Care Coordinator for help before going to an out-of-network provider. Out-of-network providers may balance bill you.

Mental Health

These services by a mental health provider are covered:

a. Behavioral health assessment
b. Office or home visits, including psychotherapy and therapy that includes biofeedback
c. Intensive outpatient program
d. Case management, skills training, wrap-around services and crisis intervention
e. Coordinated specialty program
f. Transcranial magnetic stimulation (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. Early Assessment and Support Alliance (EASA) and Assertive Community Treatment (ACT) provided by Community Mental Health Programs
b. Intensive Outpatient Services and Supports (IOSS)
c. 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

7.5.6 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.

7.5.7 Breast Reduction Surgery
Breast reduction services must be medically necessary. Breast surgeries for cosmetic purposes are excluded as described in section 7.5.36.

7.5.8 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.

7.5.9 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

7.5.10 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. Exceptions to the timelines may be made when medically necessary.

7.5.11 Diabetes Services

Pumps and other supplies are covered under the DME benefit (Section 7.5.14) when billed by a doctor. You may save more if you buy them using pharmacy plan.

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 7.5.31)

Services, medications and supplies to manage diabetes from conception through 6 weeks after giving birth are covered at no cost to you. You or your provider must contact Customer Service to get this maternal diabetes benefit.

7.5.12 Diagnostic Procedures

Services must be for treatment of a medical or behavioral 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

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 on the Moda Health website or you may ask Customer Service.

7.5.13 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. Your provider must get prior authorization.

7.5.14 Durable Medical Equipment (DME), Supplies & Appliances

Equipment and related supplies that help you manage a medical condition are covered. 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 (missing lens) or keratoconus
c. Hospital beds and accessories
d. Insulin pumps, continuous glucose monitors and other diabetes supplies
e. Intraocular lenses within 90 days of cataract surgery
f. Light boxes or light wands
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

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.

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 device, 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 devices are medically necessary
g. Testicular prostheses
h. Wigs and toupees

Neither the Plan nor Moda Health can be held 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.

7.5.15 Electrolysis
Facial electrolysis is covered if you have a diagnosis of polycystic ovary syndrome (PCOS) and hirsutism.

7.5.16 Gender Affirming Treatment
Covered services includes, but are not limited to:

a. Mental health
b. Hormone therapy (including puberty suppression therapy for adolescents)
c. Pre-surgery office visits
d. 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
e. Hair removal for surgical reconstruction or gender affirmation
f. Voice and communication training
g. Travel and lodging expenses

Expenses for gender affirming treatment are covered when you meet the following conditions:

a. Procedure(s) must be performed by a qualified professional provider
b. Prior authorization is required for surgical procedure
c. Gender affirming facial surgery must be performed at a Center of Excellence. Not all in-network providers are part of the Centers of Excellence for this benefit. Find a Center of Excellence provider at https://www.modahealth.com/pebb/medical/center_of_excellence.shtml or contact the Health Navigator team.
d. The treatment plan must conform to World Professional Association for Transgender Health, Standards of Care, Version 8

Center of Excellence is a facility and/or team of professional providers that we have agreement with 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.

7.5.17 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 or older.

We cover these items once every 3 years:

a. One hearing aid per hearing impaired ear
b. Repairs, servicing or alteration of the hearing aid equipment
c. 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)
d. Hearing assistive technology system, if necessary for appropriate amplification and prior authorized.

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
b. Initial batteries and one box of replacement batteries per year for each hearing aid

The hearing aid must be prescribed, fitted and supplied 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 26.

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.

7.5.18 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:

e. Registered or licensed practical nurse (up to 2 visits per day)
f. Physical, occupational, speech, or respiratory therapist (1 visit per day)
g. 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 7.5.14 and 7.5.19.

7.5.19 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.

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. Benefits are for services provided in what we determine is 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 that are not included in your hospice treatment plan or not specifically listed as a hospice benefit

7.5.20 Hospital Care

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

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

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.

7.5.21 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.

7.5.22 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.

7.5.23 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
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. Some services and supplies are not covered if your provider bills them separately. They are considered included in the cost of other billed charges.

7.5.24 Kidney Dialysis

Covered expenses include:

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

7.5.25 Massage Therapy
Benefits are limited to an annual dollar maximum. Other services you may get at a massage visit, such as office visits, lab and diagnostic x-rays, or physical therapy services are not covered under this benefit. They are paid under the Plan's standard benefit for the type of service.

7.5.26 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.

7.5.27 Medication Administered by Provider, Treatment/Infusion Center or Home Infusion
A medication that must be given in a professional provider's office, 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).

We may limit coverage to a preferred biosimilar medication when the biosimilar is clinically appropriate. Some medications may not be covered unless you get them from a preferred medication supplier.

See Section 7.5.23 for more information about infusion therapy.

7.5.28 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.

7.5.29 Nutritional Therapy
Dietary or nutritional therapy

a. Assessing 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) 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 7.5.11) and inborn errors of metabolism (Section 7.5.22). Nutritional therapy does not include medical foods or nutritional supplements.

7.5.30 Office or Home Visits

A visit means you are actually examined by a professional provider. Covered expenses include consultations with written reports and second opinion surgery consultations. Other services (such as lab tests) you get during the office visits are covered under the standard benefit for the type of service Office visits by naturopathic physicians are specialist office visits unless we have credentialed the naturopathic physician as a primary care provider.

7.5.31 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. Orthotics are covered under DME (see Section 7.5.14).

7.5.32 Pre-admission Testing

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

7.5.33 Rehabilitation & Habilitation

Covered rehabilitative 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 services have an annual limit. The limit does 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 or a stroke. 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.

Rehabilitative services restore or improve an ability you have lost because of 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.

Habilitative services are used to form skills that you never developed due to a medical condition. Only outpatient habilitative physical, occupational or speech therapy is only covered. It must be medically necessary to treat a mental health condition.

7.5.34 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

7.5.35 Spinal Manipulation

A limited number of visits are covered each year. 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.

7.5.36 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 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

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 Customer Service. Outpatient surgery does not require an inpatient admission or a stay of 24 hours or more. See section 4.1 for surgeries under the Additional Cost Tier benefit.

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 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.

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 7.5.16) 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

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.

7.5.37 Temporomandibular Joint Syndrome (TMJ)

TMJ related services are covered including:

a. Diagnostic exam including history, physical examination and range of motion measurements
b. Diagnostic x-rays
c. Physical therapy up to an annual visit limit
d. Therapeutic injections
e. One appliance or splint as part of a therapy that does not permanently alter tooth position, jaw position or bite.

TMJ related surgery and treatment of related dental diseases or injuries, such as dental or orthodontia services, are not covered.

7.5.38 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 Section 7.5.27.

7.5.39 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

7.5.40 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 7.5.36).

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. Travel expenses for the recipient are limited to a $5,000 combined maximum for transportation, food and lodging. Food and lodging also has a $150 daily limit.
d. Professional provider transplant services are paid according to the benefits for professional providers.
e. Immunosuppressive drugs you get during a hospital stay are paid as a medical supply.
f. 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.

Definitions

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.

7.5.41 Travel Reimbursement

Travel and lodging reimbursement is available when:

a. An in-network provider is not available within 50 miles of your home
b. Covered services are not available in your state due to a law or regulation, and the services can be received in another state legally
c. A Center of Excellence is recommended

Reimbursement must be prior authorized, and is limited to travel and lodging expenses for the patient and one adult companion to the nearest in-network provider. Reimbursement amounts are based on federal government allowances from the US General Services Administration (GSA) And are limited to:

a. Food and lodging – up to $150 per day
b. Travel, food and lodging - up to $5,000 per calendar year in total

7.5.42 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

You do not have to pay anything for virtual care visits using the preferred vendor (see Section 3). Additional technologies may be covered, and privacy and security requirements waived, during an Oregon state of emergency.

Secure online email consultations with your PCP 360 are covered when :

a. You have been treated by the PCP 360 within the last 12 months and are established as a patient
b. The e-visit is medically necessary for a covered medical condition

Other email communications are not covered, including those to renew prescriptions, schedule tests or appointments, report normal test results, recommend a referral to another physician, follow up an office visit, confirm stability of a chronic problem and continuity of present management of the problem, or communication information related to mental health or substance use disorder services.

7.6 MATERNITY CARE

Pregnancy care, childbirth and related conditions are covered when you get the care from a professional provider. See section 7.5.11 for gestational diabetes benefits. Midwives are not considered professional providers unless they are licensed or certified.

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.

Maternity care for a member who is serving as a surrogate parent is covered, except to the extent that such services are payable under the surrogate parenting contract or agreement.

7.6.1 Abortion

Abortions are covered at 100% when performed by an in-network provider.

7.6.2 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.

7.6.3 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.

7.6.4 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 Customer Service.

7.6.5 Office, Home or Hospital Visits

A visit means you are actually examined by a professional provider. In addition to pregnancy and childbirth visits, nurse home visiting services are covered (see Section 7.6.9).

7.6.6 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 want to. The attending professional provider for you and your baby will make this decision with you. You do not need a prior authorization to stay in the hospital up to these limits.

7.6.7 Fertility Services

Fertility services are only covered through Progyny. Only these services are covered:

a. Comprehensive consultations (including office visits and diagnostic testing) twice per year
b. One Progyny Smart Cycle (with option to restart cycle once if first is unsuccessful)
    a. Progyny RX (including drug counseling and support)
    b. Preconception carrier screening
    c. IUI (intrauterine insemination)
    d. IVF (in-vitro fertilization)
    e. PGT-A and PGT-M (preimplantation genetic testing for aneuploidy and monogenic/single gene defect)
    f. Sperm washing and preparation
c. Storage of legacy tissue
d. Tissue transportation from an out-of-network facility to an in-network facility
e. Telehealth visits with Progyny Providers

These services are not covered:

a. All services for gestational carriers (surrogates) not enrolled on the Plan
b. Services by providers not listed in the Progyny Member Guide

c. Home ovulation prediction kits
d. Ancillary medications such as antibiotics (refer to Judi Rx for pharmacy coverage https://app.cap-rx.com/login)
e. Additional cycles if you are covered under more than on plan.

7.6.8 Doula Services

Supportive services, such as physical, emotional and informational support to you before, during and after birth and during the postpartum period, are covered to a maximum dollar amount. Services must be provided by a doula who is certified and registered with the Oregon Health Authority (OHA).

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. If you live outside Oregon and do not have access to an OHA-registered doula, you may use the services of any doula.

7.6.9 Newborn Home Visiting Program

This program may not be available in all counties. 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.

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

Care Outside the United States
Except for care that is due to an urgent or emergency medical condition

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 (except services described in section 7.5.36.) Reconstructive gender affirming surgery is covered if medically necessary and not specifically excluded (See section7.5.16).

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 7.5.10 and 7.5.26, 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 12)

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

Homeopathic Treatment and Supplies

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

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 pending disposition of charges. Benefits paid under this exception may be limited to 115% of the Medicare allowable amount. Injuries under the Illegal Acts exclusion are not covered.

Knee Viscosupplementation

Naturopathic Services
Including herbal, naturopathic or homeopathic medicines, substances or devices and any other nonprescription supplements

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, occupational and religious 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.

Obesity or Weight Reduction
Except as covered in sections 2.4.4.1 and **7.5.4**

Orthopedic Shoes
Except as described in Section 7.5.14

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

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. An activity is considered professional or semi-professional if any of the following apply:

a. It is an event or activity you are paid or sponsored to do full-time or part-time
b. A prize (beyond a ribbon or certificate), or points toward standings that may advance you to a financial prize, is available
c. The organization is billed as "professional" and the competition in is part of the competitive events of the professional organization

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-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:

a. Employment or licensing, except when required to obtain a commercial driver license (CDL) in Oregon
b. Participating in sports or other activities
c. Insurance coverage
d. Deciding legal rights, administrative awards or benefits, corrections or social service placement.

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 health coverage
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, child, sibling, or parent, or your spouse's or domestic partner's parent.

Services Provided by Volunteer Workers

Taxes, Fees and Interest
Except as required by law

Telehealth
Except telemedicine as specifically described in Section 7.5.42 and Section **Error! Reference source not found.**.

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 7.3.1 and Section 7.5.41

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

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. You will only be covered 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 treating disease
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 7.5.11 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. Coverage is only under the medical benefit. The vitamin or mineral must require a prescription, and a dosage form of equal or greater strength of the medication is not available without a prescription under federal law. This applies whether the vitamin or mineral is oral, injectable, or transdermal. Naturopathic substances are not covered.

Wart Removal or Treatment
Except for plantar and sexually transmitted warts.

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.

Wrist Ganglion Cyst Surgery

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. Claims are not always paid 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. The Plan 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. Claims may be paid to you, to the provider, or to 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)
    iii. Proof of payment in the form of a credit card/bank statement or cancelled check

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

9.1.2 Explanation of Benefits (EOB)

We will tell you how we processed a claim in a document called an Explanation of Benefits (EOB). Claims may be paid, denied or accumulated toward satisfying the 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.

9.1.3 Claim Inquiries

Customer Service 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.

9.1.4 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.

9.1.5 Time Frames for Processing Prior Authorizations and Utilization Reviews

You will hear from us no more than 2 business days after we receive a prior authorization request. Utilization review decisions for care following emergency services will be made no more than 24 hours after receiving the request for prior authorization or coverage determination.

9.2 COMPLAINTS, APPEALS & EXTERNAL REVIEW

Before you file an appeal, call Customer Service. 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

You can fill out an appeal form (in your Member Dashboard under Resources), or send us a letter including all the identifying information from the appeal form (see "If I am not satisfied…" in Section 13). Describe what happened and what outcome you are hoping for. Include medical records or other documentation that will help us investigate your 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 the Plan agrees 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. Someone who was not involved in the original decision will investigate your appeal
c. 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 will ask you and/or your provider for the information 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 no more than 180 days after you receive the final internal adverse benefit determination. 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 **Error! Reference source not found.**)
e. Cases in which we have not met the internal timeline for review or the federal requirements for providing related information and notices

The IRO will complete their review within:

a. 3 days for expedited reviews (notification is immediate)
b. 30 days when not expedited (notification is within 5 days)

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

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
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.

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. 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 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 the Plan.

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. Your 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 this Plan is 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 this Plan 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 paid by this Plan 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, this Plan 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 the Plan will pay your covered expenses based on the understanding and

agreement that the Plan is 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 the Plan's right of recovery or subrogation. Subrogation refers to substituting one party for another in a legal setting. The Plan is 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 the Plan's subrogation and recovery rights. This includes signing and delivering any documents we reasonably require to protect the Plan's rights and providing any information or taking actions that will help us recover costs from a third party.

a. If the Plan pays 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 the Plan.

b. The Plan is entitled to be reimbursed for any benefits we pay 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. The Plan is entitled to receive the amount of benefits it has paid whether the health care expenses are itemized or expressly excluded in the third party recovery.

c. If the Plan requires you and your attorney to protect its 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 the Plan.

If you or your representatives do not comply with the requirements of this section, then the Plan 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, the Plan will advance benefits. The Plan has 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 the Plan requires you or your attorney to protect the Plan's 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, the Plan's rights under this section.

SECTION 10. ELIGIBILITY & ENROLLMENT

This section describes who is eligible for coverage and how eligible PEBB employees and dependents enroll. Benefits are not available to anyone who is not enrolled in the Plan. The PEBB eligibility rules are governed under provisions of the Oregon Administrative Rules, Chapter 101.

There is an open enrollment period each year. The effective date of coverage for new members who enroll during the open enrollment period is the beginning of the plan year for which they enroll.

10.1 SUBSCRIBER

PEBB employees are eligible for coverage as specified in the eligibility or coverage continuation requirements established by PEBB. Refer to the PEBB eligibility rules and the PEBB Summary Plan Description for detailed information on eligibility and program requirements.

10.2 DEPENDENTS

Eligible dependent means a person who is eligible for coverage by a PEBB employee as specified in the eligibility or coverage continuation requirements established by PEBB. This includes a newborn or adopted child. Refer to the PEBB eligibility rules and the PEBB Summary Plan Description for detailed information on eligibility and program requirements.

10.3 SPECIAL ENROLLMENT PERIODS

If you do not enroll in the Plan when you are first eligible, you may enroll in the Plan during a special enrollment period. Refer to the PEBB eligibility rules and the PEBB Summary Plan Description for detailed information on eligibility and program requirements.

If you were covered under Medicaid or CHIP and you become eligible for a premium assistance subsidy, you must ask for special enrollment within 60 days of becoming eligible.

10.4 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. CONTINUATION OF HEALTH COVERAGE

Check with the Group to find out if you qualify for continuation coverage. You should read the following sections carefully.

Note: Continuation of coverage under the PEBB program is governed under Chapter 101, Division 30 of the Oregon Administrative Rules. Below are summaries of some continuation coverage options. There may be additional continuation options available. Refer to the PEBB Summary Plan Description for detailed information on continuation of coverage.

11.1 COBRA CONTINUATION COVERAGE

COBRA continuation is administered by a COBRA Administrator. The Plan Sponsor, the Public Employees' Benefit Board (PEBB) is located at 1225 Ferry Street SE in Salem, Oregon or at (503) 373-1102 or 1-800-788-0520 for more information.

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, termination of a domestic partnership, 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.

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.

11.2 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.

11.3 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.

11.4 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, on time. Your workers'

compensation continuation will end early if you become employed full-time with another employer.

11.5 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 the Group 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 12. DEFINITIONS

Affidavit of Domestic Partnership is a signed and notarized document that attests the subscriber and one other eligible person meet the criteria in the affidavit to be unregistered domestic partners.

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.

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 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. 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.

Calendar Year is a period beginning January 1st and ending December 31st.

Coinsurance is a percentage of covered expense that you pay. If your coinsurance is 20%, you pay 20% of the covered charge and the Plan pays 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.

Dependent is any person who is or may become eligible for coverage under the terms of the Plan because of their relationship to the subscriber.

Domestic Partner refers to a registered domestic partner and an unregistered domestic partner as follows:

a. **Registered Domestic Partner** is a person joined with the subscriber in a partnership that has been registered in Oregon according to Oregon Family Fairness Act
b. **Unregistered Domestic Partner** is a person who has entered into a partnership with the subscriber that meets the criteria in the Plan's affidavit of domestic partnership and must have a PEBB Domestic Partner Affidavit on file with the Group.

Eligible Employee is any employee or former employee of the Group who meets the eligibility requirements to be enrolled on the Plan (see Section 10.1).]

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 clinician, 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 medical 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 dependent who becomes covered as a result of an election by the subscriber, or you become covered without an election.

Enrollment Date is, for new hires and others who enroll when first eligible, the date coverage begins or, if earlier, the first day of the waiting period. For all others, the enrollment date is the date the plan coverage actually begins.

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

The **Group** is PEBB, an organization that has contracted with Moda Health to provide claims and other administrative services. It also means the Plan Sponsor.

Group Health Plan is a health benefit plan that is made available to the employees of the Group.

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.

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 the lesser of 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 in our judgement 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 or dependent of the subscriber who is enrolled for coverage under the terms of the Plan. Where this book refers to "you" or "your" it is referring to a member.

Mental Health Condition is any mental health disorder covered by diagnostic categories listed in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5).

Mental Health Provider includes these 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. Moda Health is the claims administrator of the Plan. References to Moda Health as paying claims or issuing benefits mean that Moda Health processes a claim and the Plan Sponsor reimburses Moda Health any benefit issued. 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. Covered medical expenses are paid at a higher rate when an in-network provider is used, as shown in Section 3.

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

A **PCP 360** is a primary care clinic with professional providers who partner with you and coordinate your healthcare. You must use a PCP 360 (see section 5.2).

The **Plan** is the health benefit plan sponsored and funded by the Group Moda Health is contracted to provide claims and other administrative services.

Plan Year is the 12 month period starting on the original effective date and each 12 month period afterward.

Plan Sponsor is the Group.

Primary Care Physician (PCP) is the in-network physician or women's healthcare provider you use 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 Customer Service. 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 employee or former employee 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 13. GENERAL PROVISIONS & LEGAL NOTICES

13.1 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 360)
    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 the Plan's member rights and responsibilities policy

You have the responsibility to:

a. Read this handbook and make sure you understand the Plan. You should call Customer Service if you have any questions
b. Use a PCP 360 for primary care services
c. To the extent required by the Plan, seek medical services only from your PCP 360. This includes getting approval from your PCP 360 before going to a specialist
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 the Plan 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 Customer Service with any questions.

The Plan requires a PCP 360 to coordinate all healthcare needs. How do I know when I need a referral?
You do not need a referral. When medically necessary, your PCP 360 will direct you to an in-network provider for specialized care or services.

Will someone tell me if my PCP is no longer participating in the network?
If your PCP 360 ends their participation in the network, we will inform you and provide instructions on how to select a new PCP 360.

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 360 before you get emergency treatment. You should contact your PCP 360 as soon as reasonably possible afterward. You are covered anywhere in the world for emergency medical treatment. More information is in section 7.3.

How will I know if my benefits change or end?
The Group will notify you if your benefits change or your coverage is terminated.

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 Customer Service or visit your Member Dashboard for a list of services that require prior authorization. A

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 Customer Service.

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 Customer Service for more information.

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

a. We and PEBB 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 an appeal or a complaint be filed?
You can file an appeal or complaint by writing a letter to Moda Health. Include the following information:

a. Member name and date of birth
b. Subscriber ID number
c. Contact information (phone, email, mailing address)
d. Provider(s) involved
e. Date(s) of service
f. Medical records from the provider, if applicable
g. Reason for appeal/complaint
h. Description of what happened
i. Desired outcome

Customer Service can help you if needed. Complete information about the appeal process is in Section 9.2.

You may also contact the Department of Health and Human Services Health Insurance Assistance Team (HIAT) at 888-393-2789 about their appeal rights or for other assistance.

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

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.

13.2 General & Miscellaneous Provisions

Contract Provisions
The agreement between Moda Health and the Group 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 agreement 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 the Plan. 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 Group's Notice of Privacy Practices has more detail about how the Group and Moda Health uses your PHI. Contact the Group if you have other questions about privacy.

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 the Plan 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, the Plan has the right to recover the payment from the person paid or anyone else who benefited from it, including a provider. The Plan's 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 the Group 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 the Group or the member, a copy of which has been given to the Group 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 the Plan delays or fails to exercise any right, power or remedy provided in the Plan, including a delay or omission in denying a claim, that shall not waive the Plan's rights to enforce the provisions of the Plan.

Group is the Agent
The Group is the member's agent for all purposes under the Plan. The Group is not the agent of Moda Health.

Responsibility for Quality of Medical Care
You always have the right to choose your provider. Neither the Plan nor Moda Health are responsible for the quality of your medical care. Your providers act as independent contractors. Neither the Plan nor Moda Health can be held liable for any injuries you get while receiving medical services or supplies.

Compliance with Federal & State Mandates
The Plan 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 the Plan or 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 group plan, 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. The Plan will credit any deductible amounts you have 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.

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.

moda HEALTH

DELTA DENTAL

ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-877-605-3229 (TTY: 711) or speak to your provider.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-877-605-3229 (TTY: 711) o hable con su proveedor.

LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số (Người khuyết tật: 1-877-605-3229 (TTY: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.

주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-877-605-3229 (TTY: 711))번으로 전화하거나 서비스 제공업체에 문의하십시오.

ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-877-605-3229 (TTY: 711) или обратитесь к своему поставщику услуг.

注：日本語を話される場合、無料の言語支援サービスをご利用いただけます。アクセシブル（誰もが利用できるよう配慮された）な形式で情報を提供するための適切な補助支援やサービスも無料でご利用いただけます。1-877-605-3229 (TTY: 711) までお電話ください。または、ご利用の事業者にご相談ください。

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-877-605-3229 (TTY: 711) an oder sprechen Sie mit Ihrem Provider.

PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-877-605-3229 (TTY: 711) o makipag-usap sa iyong provider.

УВАГА: Якщо ви розмовляєте українська мова, вам доступні безкоштовні мовні послуги. Відповідні допоміжні засоби та послуги для надання інформації у доступних форматах також доступні безкоштовно. Зателефонуйте за номером 1-877-605-3229 (TTY: 711) або зверніться до свого постачальника».

ማሳሰቢያ፦ አማርኛ የሚናገሩ ከሆነ፣ የቋንቋ ድጋፍ አገልግሎት በነፃ ይቀርብልዎታል። መረጃን በተደራሽ ቅርጸት ለማቅረብ ተገቢ የሆኑ ተጨማሪ እገዛዎች እና አገልግሎቶች እንዲሁ በነፃ ይገኛሉ። በስልክ ቁጥር 1-877-605-3229 (TTY: 711) ይደውሉ ወይም አገልግሎት አቅራቢዎን ያናግሩ።

FIIRO GAAR AH: Haddaad ku hadasho Soomaali, adeegyo kaalmada luuqadda ah oo bilaash ah ayaad heli kartaa. Qalab caawinaad iyo adeegyo oo habboon si loogu bixiyo macluumaadka qaabab la adeegsan karo ayaa sidoo kale bilaa lacag heli karaa. Wac 1-877-605-3229 (TTY: 711) ama la hadal bixiyahaaga.

ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-877-605-3229 (TTY: 711) ou parlez à votre fournisseur.

注意：如果您说[中文]，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电（文本电话：1-877-605-3229 (TTY: 711)）或咨询您的服务提供商。

ຊົນຊາບ: ຖ້າທ່ານເວົ້າພາສາ ລາວ,
ຈະມີບໍລິການຊ່ວຍດ້ານພາສາແບບບໍ່ເສຍຄ່າໃຫ້ທ່ານ.
ມີເຄື່ອງຊ່ວຍ ແລະ
ການບໍລິການແບບບໍ່ເສຍຄ່າທີ່ເໝາະສົມເພື່ອໃຫ້ຂໍ້ມູນໃນຮູບ
ແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້. ໂທຫາເບີ 1-877-605-3229
(TTY: 711) ຫຼື ລົມກັບຜູ້ໃຫ້ບໍລິການຂອງທ່ານ.

หมายเหตุ: หากคุณใช้ภาษา ไทย
เรามีบริการความช่วยเหลือด้านภาษาฟรี นอกจากนี้
ยังมีเครื่องมือและบริการช่วยเหลือเพื่อให้ข้อมูลในรูปแบบที่เข้าถึง
ได้โดยไม่เสียค่าใช้จ่าย โปรดโทรติดต่อ 1-877-605-3229
(TTY: 711) หรือปรึกษาผู้ให้บริการของคุณ

توجہ دیں: اگر آپ اردو بولتے ہیں، تو آپ کے لیے زبان کی مفت مدد کی خدمات دستیاب ہیں۔ قابل رسائی فارمیٹس میں معلومات فراہم کرنے کے لیے مناسب معاون امداد اور خدمات بھی مفت دستیاب ہیں۔ - پر کال کریں یا اپنے فراہم (1-877-605-3229 (TTY: 711
کنندہ سے بات کریں۔"

LUS CEEV TSHWJ XEEB: Yog hais tias koj hais Lus Hmoob muaj cov kev pab cuam txhais lus pub dawb rau koj. Cov kev pab thiab cov kev pab cuam ntxiv uas tsim nyog txhawm rau muab lus qhia paub ua cov hom ntaub ntawv uas tuaj yeem nkag cuag tau rau los kuj yeej tseem muaj pab dawb tsis xam tus nqi dab tsi ib yam nkaus. Hu rau 1-877-605-3229 (TTY: 711) los sis sib tham nrog koj tus kws muab kev saib xyuas kho mob.

सावधान: यदि तपाईं नेपाली भाषा बोल्नुहुन्छ भने तपाईंका लागि निःशुल्क भाषिक सहायता सेवाहरू उपलब्ध छन्। पहुँचयोग्य ढाँचाहरूमा जानकारी प्रदान गर्न उपयुक्त सहायता र सेवाहरू पनि निःशुल्क उपलब्ध छन्। 1-877-605-3229 (TTY: 711) मा फोन गर्नुहोस् वा आफ्नो प्रदायकसँग कुरा गर्नुहोस्।

ശ്രദ്ധിക്കുക: നിങ്ങൾ മലയാളം ഭാഷ സംസാരിക്കുമെങ്കിൽ, സൗജന്യ ഭാഷാ സഹായ സേവനങ്ങൾ നിങ്ങൾക്ക് ലഭ്യമാണ്. ആക്സസ് ചെയ്യാവുന്ന ഫോർമാറ്റുകളിൽ വിവരങ്ങൾ നൽകാനുള്ള ഉചിതമായ അനുബന്ധ സഹായങ്ങളും സേവനങ്ങളും കൂടെ സൗജന്യമായി ലഭ്യമാണ്. 1-877-605-3229 (TTY: 711) ലേക്ക് വിളിക്കുക അല്ലെങ്കിൽ നിങ്ങളുടെ ദാതാവിനോട് സംസാരിക്കുക.

PANANGIKASO: No agsasaoka iti Ilocano, magun-odmo dagiti libre a serbisio ti tulong iti pagsasao. Libre met laeng a magun-odan dagiti maitutop a katulongan ken serbisio a mangipaay iti impormasion kadagiti ma-akses a pormat. Awagan ti 1-877-605-3229 (TTY: 711) wenno makisarita iti mangipapaay kenka.

ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 1-877-605-3229 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।

సావధానం: మీరు తెలుగు మాట్లాడితే, మీకు ఉచిత భాషా సహాయ సేవలు అందుబాటులో ఉంటాయి. యాక్సెస్ చేయగల ఫార్మాట్‌లలో సమాచారాన్ని అందించడానికి తగిన సహాయక సహాయాలు మరియు సేవలు కూడా ఉచితంగా అందుబాటులో ఉంటాయి. 1-877-605-3229 (TTY: 711) కి కాల్ చేయండి లేదా మీ ప్రొవైడర్‌తో మాట్లాడండి.

تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 877-605-3229 (TTY: 711) أو تحدث إلى مقدم الخدمة".

AKIYESI: Ti o ba sọ Yorùbá, awọn iṣẹ iranlọwọ ede ọfẹ wa fun ọ. Awọn iranlọwọ iranlọwọ ti o yẹ ati awọn iṣẹ lati pese alaye ni awọn ọna kika wiwọle tun wa laisi idiyele. Pe 1-877-605-3229 (TTY: 711) tabi sọrọ si olupese rẹ.

MAKINIKA: Ikiwa wewe huzungumza Kiswahili, msaada na huduma za lugha bila malipo unapatikana kwako. Vifaa vya usaidizi vinavyofaa na huduma bila malipo ili kutoa taarifa katika mifumo inayofikiwa pia inapatikana bila malipo. Piga simu 1-877-605-3229 (TTY: 711) au zungumza na mtoa huduma wako.

ATENÇÃO: Se você fala Português do Brasil, serviços gratuitos de assistência linguística estão disponíveis para você. Auxílios e serviços auxiliares apropriados para fornecer informações em formatos acessíveis também estão disponíveis gratuitamente. Ligue para 1-877-605-3229 (TTY: 711) ou fale com seu provedor.

For help, call us directly at 844-776-1593
(En español: 888-786-7461)