Oregon
Individual Policy

Moda Health Beacon Be Prepared Silver 3000 Plan
($3,000 Deductible Plan)

This policy is authorized by the signature of Moda Health's representative.

Tracie Murphy

Tracie Murphy
Senior Vice President

The subscriber may return this policy to Moda Health within 10 days of its delivery and have the premium paid refunded. In such a case, this policy shall then be voided from the beginning and Moda Health will hold the position as if no policy has been issued.

modahealth.com

Health plans in Oregon by Moda Health Plan, Inc.

Moda Health renews this individual plan on January 1 each year, including benefit and rate adjustments. Rates may also change when the family composition changes, or the subscriber moves into a different rating area, with new rates effective the first of the following month.

Individual policies and other services are available at www.modahealth.com.

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SECTION 1. WELCOME

Moda Health is pleased to provide individual health coverage to members through the Moda Health Beacon Be Prepared Silver 3000 Plan. This policy is designed to provide members important information about the Plan's benefits, limitations and procedures.

Members may direct questions to one of the numbers listed below or access tools and resources on Moda Health's personalized member website, myModa, at www.modahealth.com. myModa is available 24 hours a day, 7 days a week allowing members to access plan information whenever it's convenient.

Moda Health reserves the right to monitor telephone conversations and e-mail communications between its employees and its customers for legitimate business purposes as determined by Moda Health.

This policy is a description of members' individual health coverage. This policy may be changed or replaced without the consent of any member other than the subscriber. The most current policy is available on myModa, accessed through the Moda Health website. All provisions are governed by this policy between the subscriber and Moda Health.

IMPORTANT NOTE: IF CHILD ONLY COVERAGE

If this is a child only plan, all references in this policy to dependents, including a spouse, domestic partner or children, are considered deleted. Siblings of the subscriber are eligible.

Insurance products provided by Moda Health Plan, Inc.
Portland, Oregon

SECTION 2. MEMBER RESOURCES

2.1 CONTACT INFORMATION

Moda Health Website (log in to **myModa**)
www.modahealth.com
Includes many helpful features, such as:
Find Care (use to find an in-network provider)
Prescription price check tool and formulary (medication cost estimates and benefit tiers)
Prior authorization lists (services and supplies that may require authorization www.modahealth.com/medical/referrals)

Medical Customer Service Department
888-393-2940
En Español 888-786-7461

Behavioral Health Customer Service Department
800-799-9391

Disease Management and Health Coaching
877-277-7281

Pharmacy Customer Service Department
844-235-8015

Dental Customer Service Department
844-235-8013
En Español 877-299-9063

Telecommunications Relay Service for the hearing impaired
711

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

2.2 MEMBERSHIP CARD

After enrolling, members will receive identification cards that will include the identification number. Members will need to present the card each time they receive services. Members may go to myModa or contact Customer Service for replacement of a lost identification card.

2.3 NETWORKS

See Network Information (Section 3) for more detail about how networks work.
Medical Network
Beacon

Pharmacy Network
MedImpact

Dental Network
Delta Dental Premier

Travel Network
First Health

2.4 CARE COORDINATION

2.4.1 Care Coordination

The Plan provides individualized coordination of complex or catastrophic cases. Care Coordinators and Case Managers who are nurses or behavioral health clinicians work directly with members, their families, and their professional providers to coordinate healthcare needs.

The Plan will coordinate access to a wide range of services spanning all levels of care depending on the member's needs. Having a nurse or behavioral health clinician available to coordinate these services ensures improved delivery of healthcare services to members and their professional providers.

2.4.2 Disease Management

The Plan provides education and support to help members manage a chronic disease or medical condition. Health Coaches help members to identify their healthcare goals, self-manage their disease and prevent the development or progression of complications.

Working with a Health Coach can help members follow the medical care plan prescribed by a professional provider and improve their health status, quality of life and productivity.

Contact Disease Management and Health Coaching for more information.

2.4.3 Behavioral Health

Moda Behavioral Health provides specialty services for managing mental health and chemical dependency benefits to help members access effective care in the right place and contain costs. Behavioral Health Customer Service can help members locate in-network providers and understand the mental health and chemical dependency benefits.

2.5 OTHER RESOURCES

Additional member resources providing general information about the Plan can be found in Section 14 and Section 15.

SECTION 3. NETWORK INFORMATION

In-network benefits apply to services delivered by in-network providers. Out-of-network benefits apply to services delivered by out-of-network providers. By using an in-network provider, members will receive quality healthcare and will have a higher level of benefits. Services a member receives in an in-network facility may be provided by physicians, anesthesiologists, radiologists or other professionals who are out-of-network providers. When a member receives services from these out-of-network providers, any amounts charged above the MPA may be the member's responsibility.

Remember to ask providers to send any lab work or x-rays to an in-network facility for the highest benefits. Members may choose an in-network provider by using "Find Care" on myModa or by contacting Customer Service for assistance. Member ID cards will identify the applicable network.

3.1 GENERAL NETWORK INFORMATION

3.1.1 Primary Network; Primary Service Area

Members have access to a primary network, which provides services in their primary service area. Subscribers who move outside of a network service area must contact Customer Service to find out if another plan is available to ensure continued coverage.

Network

For all members:
Medical network is Beacon, with providers in Clackamas, Clatsop, Columbia, Coos, Curry, Hood River, Jackson, Josephine, Marion, Multnomah, Polk, Tillamook, Wasco, Washington and Yamhill counties
Pharmacy network is MedImpact
Dental Network is Delta Dental Premier

3.1.2 Coverage Outside the Service Area for Children

Enrolled children residing in the United States but outside Oregon may receive the in-network benefit level, subject to the following limitations:

a. All non-emergency hospital confinements must be prior authorized
b. Services will be paid at the in-network benefit level if provided within a 30-mile radius of the child's residence or at the closest appropriate facility
c. Services will be paid at the out-of-network benefit level if such services are provided outside the 30-mile radius of the child's residence
d. Out-of-area and out-of-network providers may bill members for charges in excess of the maximum plan allowance

Children will receive the best out-of-area benefit by using a travel network provider as described in section 3.1.3 if one is available. When an enrolled child moves outside the service area, members must contact Customer Service to update the address in the system. The enrolled child will be eligible for out-of-area coverage on the first day of the month following the date the address is updated in the system.

Children inside Oregon but outside the Plan's services area will receive out-of-network benefits. In-network benefits are not available to a child residing outside the service area for the purpose of receiving treatment or benefits.

3.1.3 Travel Network

Members traveling outside of Oregon may receive in-network benefits by using a travel network provider for urgent or emergency services. The in-network benefit level only applies to a travel network provider if members are outside the state of Oregon and the travel is not for the purpose of receiving treatment or benefits. The travel network is not available to members who are temporarily residing outside the primary service area, except for enrolled children residing in the United States but outside the primary service area.

Travel Network
First Health

Members may find a travel network provider by using "Find Care" on myModa or by contacting Customer Service for assistance.

3.1.4 Out-of-Network Care

When members use healthcare providers that are not in-network, the benefit from the Plan is lower, at the out-of-network level described in section 4.1. In most cases the member must pay the provider all charges at the time of treatment, and then file a claim to be reimbursed the out-of-network benefit. If the provider's charges are in excess of the maximum plan allowance, the member is responsible for paying those excess charges.

3.1.5 Care After Normal Office Hours

In-network professional providers have an on-call system to provide 24-hour service. Members who need to contact their professional provider after normal office hours should call his or her regular office number.

3.2 PHYSICIAN AND PROVIDER SYSTEM

The Plan is designed to support members' healthcare needs through partnership between a member and an in-network primary care provider (PCP) who can coordinate care. Each member must select an in-network PCP at the time of enrollment. Moda Health may assign a PCP to members who do not select one. Members will be notified if a PCP is assigned. The PCP can be changed at any time through myModa or by contacting Customer Service.

A directory of in-network PCPs is available on myModa under "Find Care" or by contacting Customer Service for assistance. Each member may select a different PCP. Enrolled children may choose a pediatrician, and female members are permitted to designate a women's healthcare provider.

SECTION 4. SUMMARY OF BENEFITS – A QUICK REFERENCE

This section is a quick reference summarizing the Plan's benefits. The details of the actual benefits and the conditions, limitations and exclusions are contained in the sections that follow. An explanation of important terms is found in Section 7.

Section 5.1 provides information regarding prior authorization requirements. Members can access a complete list of procedures that require prior authorization on myModa or by contacting Customer Service. Failure to obtain required prior authorizations may result in denial of benefits.

4.1 SCHEDULE OF BENEFITS

All "annual" or "per year" benefits accrue on a calendar year basis unless otherwise specified.

"Cost sharing" is the amount members pay. For services provided out-of-network, members are also responsible for any amount in excess of the maximum plan allowance.

	In-Network Benefits	**Out-of-Network Benefits**
Annual deductible per member	**$3,000**	**$12,000**
Maximum annual family aggregate deductible	**$6,000**	**$24,000**
Annual out-of-pocket maximum per member	**$7,350**	**$29,400**
Maximum annual aggregate out-of-pocket maximum per family	**$14,700**	**$58,800**

Services	**Cost Sharing** (Deductible applies unless noted differently)		**Section in Handbook & Details**
	In-network	**Out-of-network**	
Emergency Care			
Emergency Room Facility	30%	30% (In-network deductible and out-of-pocket maximum apply)	Section 8.2
Hospital and Residential Facility Care			
Inpatient Acute Care	30%	50%	Section 8.3.3
Inpatient Rehabilitation and Habilitation (Physical, occupational and speech therapy)	30%	50%	Section 8.3.4 30 days per year, or 60 days following head/spinal cord injury (N/A to mental health/ chemical dependency)

Services	Cost Sharing (Deductible applies unless noted differently)		Section in Handbook & Details
	In-network	Out-of-network	
Skilled Nursing Facility Care	30%	50%	Section 8.3.5 60 days per year
Residential Mental Health & Chemical Dependency Treatment Programs	30%	50%	Section 8.3.6
Chemical Dependency Detoxification	30%	50%	Section 8.3.7
Ambulatory Services			
Outpatient Surgery and Invasive Diagnostic Procedures (Facility Charges)	30%	50%	Section 8.4.1
Outpatient Rehabilitation and Habilitation (Physical, occupational and speech therapy)	$70 per visit, no deductible	50%	Section 8.4.2 30 sessions per year. May be eligible for up to 60 sessions for treatment of neurologic conditions. (N/A to mental health/ chemical dependency)
Infusion Therapy (Home or Outpatient)	30%	50%	Section 8.4.3 Some medications may require use of authorized provider to be eligible for coverage. Outpatient hospital setting not covered for some medications.
Diagnostic Procedures, including x-ray and lab	30%	50%	Section 8.4.4
Therapeutic X-ray	30%	50%	Section 8.4.5
Kidney Dialysis	30%	50%	Section 8.4.5
Outpatient Chemical Dependency Services	$35 per visit, no deductible	50%	Section 8.4.6
Professional Services			
Preventive Healthcare			Section 8.5.1
Services as required under the Affordable Care Act, including the following:	No cost sharing	Not covered except as stated	
Preventive Health Exams	No cost sharing	Not covered	7 exams age 1- 4 One per year, age 5+
Immunizations	No cost sharing	Not covered	

Services	Cost Sharing (Deductible applies unless noted differently)		Section in Handbook & Details
	In-network	Out-of-network	
Newborn Hearing Screening	No cost sharing	Not covered	
Routine Vision Screening	No cost sharing	Not covered	Age 3 – 5
Women's Exam & Pap Test	No cost sharing	50%	One per year
Routine Mammogram	No cost sharing	50%	One age 35 – 40 One per year, age 40+
Routine Colonoscopy	No cost sharing	Not covered	One per 10 years, age 50+
Other Preventive Services including:			
Routine Diagnostic X-ray & Lab	30%	50%	
Prostate Rectal Exam	$35 per visit, no deductible	50%	One per year, age 50+
Prostate Specific Antigen (PSA) Test	30%	50%	One per year, age 50+
Urgent Care, Home and Office Visits	$35 per visit, no deductible	50%	Section 8.5.2
Specialist Visits (including naturopath visits)	$70 per visit, no deductible	50%	
Physician Hospital Visits	30%	50%	
Diabetes Services	30%	50%	Section 8.5.4
Therapeutic Injections	30%	50%	Section 8.5.6
Surgery	30%	50%	Section 8.5.7
Pediatric Dental Care			Section 8.5.14
Preventive & Diagnostic	No cost sharing	50%	Frequency limits apply
Other dental services	30%	50%	
Dental Injury	30%	50%	Section 8.5.15
Alternative Care (Spinal Manipulation and Acupuncture Services)	$35 per visit, no deductible	50%	Section 8.5.18 $1,000 combined annual maximum
Applied Behavior Analysis			Section 8.5.19
Office Visits	$35 per visit, no deductible	50%	
Other Services	30%	50%	
Outpatient Mental Health Services	$35 per visit, no deductible	50%	Section 8.5.20
Tobacco Cessation Treatment			Section 8.5.23
Consultation	No cost sharing	Not covered	
Supplies	No cost sharing	50%	

Services	Cost Sharing (Deductible applies unless noted differently)		Section in Handbook & Details
	In-network	Out-of-network	
Other Services			
Ambulance Transportation	30%	30% (in-network deductible and out-of-pocket maximum apply)	Section 8.6.1 6 trips per year
Hospice Care			Section 8.6.2
Home Care	30%	50%	
Inpatient Care	30%	50%	
Respite Care	30%	50%	30 day lifetime maximum, up to 5 days consecutive
Maternity	30%	50%	Section 8.6.3
Breastfeeding			Section 8.6.4
Support and Counseling	No cost sharing	Not covered	
Supplies	No cost sharing	No cost sharing	
Transplants			Section 8.6.5 $7,500 maximum travel and housing expense per transplant
Authorized transplant facilities	30%	N/A	
Other facilities	Not covered	Not covered	
Biofeedback	$70 per visit, no deductible	50%	Section 8.6.6 10 visit lifetime maximum
Home Healthcare	30%	50%	Section 8.6.7 140 out-of-network visits per year
Outpatient Durable Medical Equipment	30%	50%	Section 8.6.8 One wheelchair per year under age 19 and every 3 years age 19+
Wigs	67%	67%	Section 8.6.8 One per year
Supplies and Appliances	30%	50%	Section 8.6.8
Hearing Aids and Related Services	30%	50%	Section 8.6.9 Once every 48 months
Pediatric Vision Care			Section 8.6.10
Exam	$35 per visit, no deductible	50%	One exam and one pair of glasses or contacts per year under age 19
Lenses & frames or contacts	30%	50%	

Services	Cost Sharing (Deductible applies unless noted differently)		Section in Handbook & Details
	In-network	Out-of-network	
Medications			
Anticancer Medication	30%	50%	Section 8.8.2 If purchased at pharmacy, subject to deductible as it applies to pharmacy benefits
Prescription Medication			Section 8.9
Retail and Specialty Pharmacy			Up to 30-day supply per prescription
Value	$2, no deductible	$2, no deductible	
Select	$20, no deductible	$20, no deductible	
Preferred	40%, no deductible	40%, no deductible	
Brand	50%	50%	
Specialty	50%	Not covered	
Mail Order Pharmacy			Up to 90-day supply per prescription
Value	$6, no deductible	$6, no deductible	
Select	$60, no deductible	$60, no deductible	
Preferred	40%, no deductible	40%, no deductible	
Brand	50%	50%	
Specialty	50%	Not covered	
Additional Accident Benefit			
Additional Accident Benefit	No cost sharing	No cost sharing	Section 8.7 $1,000 maximum Services must be completed within 90 days of the injury

4.2 DEDUCTIBLES

The Plan has an annual deductible. The deductible amounts are shown in section 4.1, and are the amount of covered expenses that are paid by a member before benefits are payable by the Plan. That means the member pays the full cost of services that are subject to the deductible until he or she has spent the deductible amount. Then the Plan begins sharing costs with the member. In-network and out-of-network amounts accumulate separately. The deductible is lower when using in-network providers. After the deductible has been satisfied, benefits will be paid according to section 4.1. When a per member deductible is met, benefits for that member will be paid according to section 4.1. If coverage is for more than one member, the per member deductible applies only until the total family deductible is reached.

Disallowed charges and copayments do not apply toward the deductible.

4.3 ANNUAL MAXIMUM OUT-OF-POCKET

After the annual per member or per family out-of-pocket maximum is met, the Plan will pay 100% of covered services for the remainder of the year. If coverage is for more than one member, the per member maximum applies only until the total family out-of-pocket maximum is reached. In-network and out-of-network out-of-pocket maximums accumulate separately and are not combined.

Members are responsible for disallowed charges, including amounts over the MPA. They do not accrue toward the out-of-pocket maximum and members must pay for them even after the out-of-pocket maximum is met.

4.4 PAYMENT

Expenses allowed by Moda Health are based upon the maximum plan allowance, which is a contracted fee for in-network providers and for out-of-network providers is an amount established, reviewed, and updated by a national database. Depending upon the Plan provisions, cost sharing may apply.

Except for cost sharing and policy benefit limitations, in-network providers agree to look solely to Moda Health, if it is the paying insurer, for compensation of covered services provided to members.

SECTION 5. PRIOR AUTHORIZATION

Prior authorization programs are not intended to create barriers or limit access to services. Requiring prior authorization ensures member safety, promotes proper use of services and medications, and supports cost effective treatment options for members. Services requiring prior authorization are evaluated with respect to evidence based criteria that align with medical literature, best clinical practice guidelines and guidance from the FDA. Moda Health will authorize medically necessary services, supplies or medications based upon the medical condition. Treatments are covered only upon medical evidence of need.

When a professional provider suggests a type of service requiring authorization (see section 5.1.1), the member should ask the provider to contact Moda Health for prior authorization. Authorization for emergency hospital admissions must be obtained by calling Moda Health within 48 hours of the hospital admission (or as soon as reasonably possible). The hospital, professional provider and member are notified of the outcome of the authorization process by letter. Prior authorization does not guarantee coverage. When a service is otherwise excluded from benefits, charges will be denied.

5.1 PRIOR AUTHORIZATION REQUIREMENTS

Members using an out-of-network provider are responsible for ensuring that their provider contacts Moda Health for prior authorization. Services not authorized in advance will be denied, and the full charge will be the member's responsibility.

Any amounts that are member responsibility due to not obtaining a prior authorization do not apply toward the Plan's deductible or out-of-pocket maximum.

In-network providers are responsible for obtaining prior authorization on the member's behalf. If the in-network provider does not do so, he or she is expected to write off the full charge of the service.

Prior authorization is not required for an emergency admission.

5.1.1 Services Requiring Prior Authorization

Many services within the following categories may require prior authorization:

a. Inpatient services and residential programs
b. Outpatient or ambulatory services
c. Rehabilitation
d. Chiropractic or acupuncture services for musculoskeletal conditions
e. Imaging services
f. Infusion therapy
g. Medications

A full list of services and supplies requiring prior authorization may be found on the Moda Health website. This list is updated periodically, and members should ask their provider to check to see if a service or supply requires authorization. A member may obtain authorization information by contacting Customer Service. For mental health or chemical dependency services, contact Behavioral Health Customer Service.

SECTION 6. COST CONTAINMENT

6.1 SECOND OPINION

Moda Health may recommend an independent consultation to confirm that non-emergency treatment is medically necessary. The Plan pays the full cost of the second opinion with any deductible waived.

6.2 COST EFFECTIVENESS SERVICES

Cost effectiveness services are services or supplies that are not otherwise benefits of the Plan, but which Moda Health believes to be medically necessary, cost effective and beneficial for quality of care. Moda Health works with members and their professional providers to consider effective alternatives to hospitalization and other care to make more efficient use of the Plan's benefits. After case management evaluation and analysis by Moda Health, cost effective services agreed upon by a member and his or her professional provider and Moda Health will be covered. Any party can also provide notification in writing and terminate such services.

The fact that the Plan has paid benefits for cost effectiveness services for a member shall not obligate it to pay such benefits for any other member, nor shall it obligate the Plan to pay benefits for continued or additional cost effectiveness services for the same member. All amounts paid for cost effectiveness services under this provision shall be included in computing any benefits, limitations or cost sharing under the Plan.

SECTION 7. DEFINITIONS

Ambulatory Care means medical care provided on an outpatient basis. Ambulatory care is given to members who are not confined to a hospital.

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

Applied Behavior Analysis means a variety of psychosocial interventions that use behavioral principles to shape an individual's behavior. It includes direct observation, measurement and functional analysis of the relationship between environment and behavior. It is a type of treatment for individuals with autism spectrum disorder. Typical 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.

Authorization see Prior Authorization.

Autism Service Provider means a behavior analyst licensed by the Oregon Behavior Analysis Regulatory Board (BARB), an assistant behavior analyst licensed by BARB and practicing under the supervision of a behavior analyst, an interventionist registered by BARB and practicing under the supervision of a behavior analyst, or a state-licensed or state-certified healthcare professional providing services for autism spectrum disorder within the scope of his or her professional license. In states that do not license autism service providers, certification or registration with the Behavior Analysis Certification Board may be accepted instead.

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

Chemical Dependency means an addictive physical and/or psychological relationship with any drug or alcohol that interferes on a recurring basis with an individual's main life areas, such as employment, and psychological, physical and social functioning. Chemical dependency does not mean an addiction to or dependency upon foods, tobacco, or tobacco products.

Chemical Dependency Outpatient Treatment Program means a state-licensed program that provides an organized outpatient course of treatment, with services by appointment, for substance-related disorders.

Coinsurance means the percentages of covered expenses to be paid by a member.

Copay or **Copayment** means the fixed dollar amounts to be paid by a member to a provider when receiving a covered service.

Cost Sharing is the share of costs a member must pay when receiving a covered service, including 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 a member conduct such common activities as bathing, eating, dressing or getting in and out of bed. It is care that can be provided by people without medical or paramedical skills. Custodial care includes care that is primarily for the purpose of

keeping a member safe or for holding a member awaiting admission to the appropriate level of care.

Dental Care means services or supplies provided to prevent, diagnose or treat diseases of the teeth and supporting tissues or structures, including services or supplies to restore the ability to chew and to repair defects that have developed because of tooth loss.

Dependent means any person who is or may become eligible for coverage under the terms of this policy because of a relationship to the subscriber.

Domestic Partner means a person joined with the subscriber in a partnership that has been registered under the laws of any federal, state or local government.

Effective Date means the 1st of the following month if an application is received on the 1st to 15th of a month, or the 1st of the second month if an application is received from the 16th to the last day of a month. For new dependents, effective date means the date of birth for a newborn child, the date of the adoption decree for an adopted child, and the date of placement for a child placed for adoption or foster care. For new spouses and domestic partners, and persons who qualify due to loss of minimum essential coverage, it means the 1st day of the month following the qualifying event.

Emergency Medical Condition means 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 that failure to receive immediate medical attention would place the health of a member, or a fetus in the case of a pregnant woman, in serious jeopardy.

Emergency Medical Screening Examination means 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.

Emergency Services means those healthcare items and services furnished in an emergency department of a hospital. All related services routinely available to the emergency department to the extent they are required for the stabilization of a member, and within the capabilities of the staff and facilities available at the hospital are included. Emergency services also include further medical examination and treatment required to stabilize a member.

Experimental or Investigational means services and supplies 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
b. Are available in the United States only as part of a 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

Genetic Information pertains to a member or his or her relative, and means information about genetic tests, a request for or receipt of genetic services, or participation in clinical research that includes genetic services. It also includes a disease or disorder in a member's relative.

Health Benefit Plan means 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 means a disease or bodily disorder that results in a covered service.

Implant means a material inserted or grafted into tissue.

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

In-network refers to providers that are contracted under Moda Health or Delta Dental to provide care to members.

Intensive Outpatient means an appropriately licensed mental health or chemical dependency facility providing less than 20 hours of direct, structured treatment services per week.

Maximum Plan Allowance (MPA) is the maximum amount Moda Health 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 Moda Health may have in place or the amount calculated using one of the following methodologies, any of which may be used by Moda Health: a percentage of the Medicare allowable amount, 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 received out-of-network is the greatest of the median in-network rate, the maximum amount as calculated according to this definition for out-of-network providers and the Medicare allowable amount.

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

MPA for an out-of-network dental provider is based on a per service average allowance of the in-network amount.

In certain instances, when a dollar value is not available, Moda Health reviews the claim to determine a comparable code to the one billed. Once a comparable code is established, the claim is processed as described above.

When using an out-of-network provider, any amount above the MPA is the member's responsibility.

Medical Condition means any physical or mental condition including one resulting from illness, injury (whether or not the injury is accidental), pregnancy or congenital malformation. Genetic information in and of itself is not a condition.

Medical Services Contract means a contract between an insurer and an independent practice association or a provider. Medical services contract does not include a contract of employment or a contract creating legal entities.

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

a. it is consistent with the symptoms or diagnosis of a member's condition and appropriate considering the potential benefit and harm to the patient
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.

Moda Health may require proof that services, interventions, supplies or medications (including court-ordered care) are medically necessary. No benefits will be provided 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 proof of medical necessity is required but not provided by the health service provider.

Medically necessary care does not include custodial care.

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

More information regarding medical necessity can be found in the General Exclusions (Section 9).

Member means a person whose application for individual health coverage has been accepted and who is enrolled for coverage under the terms of this policy. A member may be the subscriber or a dependent of a subscriber.

Mental Health refers to benefits, facilities, programs, levels of care and services related to the assessment and treatment of mental health conditions, as defined in the policy.

Mental Health Condition means any mental health disorder covered by diagnostic categories listed in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition Text Revision (DSM-IV-TR) or the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)

Mental Health Provider means a board-certified psychiatrist or any of the following state-licensed professionals: a psychologist, a psychologist associate, a psychiatric mental health nurse practitioner, a clinical social worker, a mental health counselor, a marriage and family therapist,

or a clinician providing services in a program licensed, approved, established, maintained, contracted with or operated by the Oregon Office of Mental Health & Addiction Services.

Moda Health refers to Moda Health Plan, Inc.

Network means a group of providers who contract to provide healthcare to members at negotiated rates. Such groups are called Preferred Provider Organizations (PPOs), and provide in-network services in their specific service areas. Covered medical expenses will be paid at a higher rate when an in-network provider is used (see section 4.1).

Out-of-network refers to providers that are not contracted under Moda Health or Delta Dental to charge discounted rates to members.

Out-of-Pocket Maximum means the maximum amount a member pays out-of-pocket every year, including the deductible, coinsurance and copays. If a member obtains both in-network and out-of-network services, 2 separate out-of-pocket maximums apply. If a member reaches the out-of-pocket maximum in a calendar year, the Plan will pay 100% of eligible expenses for the remainder of the year.

Outpatient Surgery means surgery that does not require an inpatient admission or overnight (less than 24 hours) stay.

Partial Hospitalization means an appropriately licensed mental health or chemical dependency facility providing no less than 4 hours of direct, structured treatment services per day.

The **Plan** is the individual health benefit plan insured under the terms of this policy between the subscriber and Moda Health.

Policy means the contract between the subscriber and Moda Health that contains all the conditions of the insurance coverage. The policy includes this handbook, the individual application, and any declaration pages, addendums, endorsements, or amendments.

Prior Authorization or **Prior Authorized** refers to obtaining approval by Moda Health prior to the date of service. A complete list of services and medications that require prior authorization is available on myModa or by contacting Customer Service. Failure to obtain required authorization will result in denial of benefits (see section 5.1).

Professional Provider means any state-licensed or state-certified healthcare professionals, when providing medically necessary services within the scope of their licenses or certifications. In all cases, the services must be covered under the Plan to be eligible for benefits.

Provider means 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 to a member.

Residential Program means a state licensed program or facility providing an organized full-day or part-day program of treatment. Residential programs provide overnight 24-hour per day care and include programs for treatment of mental health conditions or chemical dependency. Residential program does not include any program that provides less than 4 hours per day of direct treatment services.

Respite Care means care for a period of time to provide caregivers relief from full-time residing with and caring for a member. Providing care to allow a caregiver to return to work does not qualify as respite care.

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

Subscriber means the person in whose name the policy is issued following acceptance by Moda Health of that person's individual application.

Urgent Care means immediate, short-term medical care provided by an urgent or immediate care facility for minor but urgent medical conditions that do not pose a significant threat to life or health at the time the services are rendered.

Women's Healthcare Provider means an in-network obstetrician or gynecologist, physician assistant specializing in women's health, advanced registered nurse practitioner specializing in women's health or certified nurse midwife, practicing within the applicable lawful scope of practice. A women's healthcare provider designated as a PCP must meet certain standards and must have requested and received designation from Moda Health as a PCP.

SECTION 8. BENEFIT DESCRIPTION

The Plan covers services and supplies listed when medically necessary for diagnosis and/or treatment of a medical condition, as well as certain preventive services. The details of the different types of benefits and the conditions, limitations and exclusions are described in the sections that follow. An explanation of important terms is found in Section 7.

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 4.1).

Many services require prior authorization. A complete list is available on myModa or by contacting Customer Service. Failure to obtain required prior authorization will result in denial of benefits (see section 5.1).

8.1 WHEN BENEFITS ARE AVAILABLE

The Plan only pays claims for covered services obtained when a member's coverage is in effect. Coverage is in effect when the member:

a. Is eligible to be covered according to the eligibility provisions of this policy
b. Has applied for coverage and has been accepted
c. Has paid his or her premiums on time for the current month

If a member is in a hospital or other special facility, including skilled nursing facility, on the day coverage ends, the Plan will only pay for those covered services and supplies provided before coverage ends.

8.2 EMERGENCY CARE

Members are covered for treatment of emergency medical conditions (as defined in Section 7) worldwide. A member who believes he or she has a medical emergency should call 911 or seek care from the nearest appropriate provider.

All emergency services (as defined in Section 7) will be reimbursed at the in-network benefit level. Out-of-network providers may bill members for charges in excess of the maximum plan allowance. Using an in-network emergency room does not guarantee that all providers working in the emergency room and/or hospital are also in-network providers.

Prior authorization is not required for emergency medical screening exams or treatment to stabilize an emergency medical condition, whether in-network or out-of-network.

If a member's condition requires hospitalization in an out-of-network facility, the attending physician and Moda Health's medical director will monitor the condition and determine when the transfer to an in-network facility can be made. The Plan does not provide the in-network benefit level for care beyond the date the attending physician and Moda Health's medical director determine the member can be safely transferred.

Care received outside of the United States is only covered for an urgent care or emergency medical condition. Emergency services will be reimbursed at the in-network benefit level. Members will need to pay for these services upfront and submit a claim to Moda Health for reimbursement (as described in section 12.1).

The in-network benefit level is not available for out-of-network care other than emergency medical care. The following are not emergency medical conditions and are not eligible for the in-network benefit level (this is not inclusive of all such services):

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

8.3 HOSPITAL & RESIDENTIAL FACILITY CARE

The details of the hospital and residential facility care benefits and the conditions, limitations and exclusions are described in the sections that follow. An explanation of important terms is found in Section 7. All facility care must be medically necessary in order to be covered.

A hospital is a facility that is licensed to provide inpatient and outpatient surgical and medical care to members who are acutely ill. Services must be under the supervision of licensed physicians and include 24-hour-a-day nursing service by licensed registered nurses.

Hospitalization must be directed by a physician and must be medically necessary. All inpatient and residential stays require prior authorization (see section 5.1). Failure to obtain authorization will result in denial of benefits.

Facilities operated by agencies of the federal government are not considered hospitals. However, the Plan will cover expenses incurred in facilities operated by the federal government where benefit payment is mandated by law. Any covered service provided at any hospital owned or operated by the state of Oregon is also eligible for benefits.

8.3.1 Emergency Room Care

Medically necessary emergency room care is covered. See section 8.2 for more information. The emergency room benefit applies to services billed by the facility. Professional fees (e.g., emergency room physician, or x-ray/lab) billed separately are paid under other benefits.

8.3.2 Pre-admission Testing

Medically necessary preadmission testing is covered when ordered by the physician.

8.3.3 Hospital Benefits

The Plan allows benefits for acute hospital care. Covered expenses consist of the following:

a. **Hospital room.** The actual daily charge
b. **Isolation care.** When it is medically necessary to protect a member from contracting the illness of another person or to protect other patients from contracting the illness of a member

c. **Intensive care unit.** Whether a unit in a particular hospital qualifies as an intensive care unit is determined using generally recognized industry standards
d. **Facility charges.** For surgery performed in a hospital outpatient department
e. **Other hospital services and supplies.** Those medically necessary for treatment and ordinarily furnished by a hospital
f. **Routine nursery care.** Includes one in-nursery physician's visit of well-newborn infant while the mother is confined in the hospital and receiving maternity benefits. The deductible is waived for routine nursery care

Coverage for take-home prescription drugs following a period of hospitalization will be limited to a 3-day supply at the same benefit level as for hospitalization.

8.3.4 Inpatient Rehabilitative and Habilitative Care

To be a covered expense, rehabilitative services must be a medically necessary part of a physician's formal written program to improve and restore lost function following illness or injury.

Covered rehabilitative and habilitative care expenses are subject to an annual limit for inpatient services that specialize in such care. Additional days may be available for rehabilitation after acute head or spinal cord injury, subject to medical necessity and prior authorization. Limits apply separately to rehabilitative and habilitative care. Medically necessary services for mental health and chemical dependency are not subject to these limits.

8.3.5 Skilled Nursing Facility Care

A skilled nursing facility is a facility licensed under applicable laws to provide inpatient care under the supervision of a medical staff or a medical director. It must provide rehabilitative services and 24-hour-a-day nursing services by registered nurses.

Covered skilled nursing facility days are subject to an annual limit. Covered expenses are limited to the daily service rate, but no more than the amount that would be charged if the member were in a semi-private hospital room.

The Plan will not pay charges related to an admission to a skilled nursing facility before the member was covered by this policy or for a stay where care is provided principally for:

a. Senile deterioration
b. Alzheimer's disease
c. Mental health condition

Expenses for routine nursing care, non-medical self-help or training, personal hygiene or custodial care are not covered.

8.3.6 Residential Mental Health and Chemical Dependency Treatment Programs

All-inclusive daily charges for room and treatment services, including partial hospitalization, by a treatment program that meets the definitions in the Plan are covered.

8.3.7 Chemical Dependency Detoxification Program

All-inclusive daily charges for room and treatment services by a state-licensed treatment program.

8.4 AMBULATORY SERVICES

Many ambulatory services require prior authorization (see section 5.1). All services must be medically necessary.

8.4.1 Outpatient Surgery

The Plan covers operating rooms and recovery rooms, surgical supplies and other services ordinarily provided by a hospital or surgical center.

Certain surgical procedures are covered only when performed as outpatient surgery. Members should ask their professional provider if this applies to a proposed surgery, or contact Customer Service.

8.4.2 Outpatient Rehabilitation and Habilitation

Rehabilitative and habilitative services are physical, occupational or speech therapies provided by a licensed physical, occupational or speech therapist, physician, chiropractor or other professional provider licensed to provide such services. Rehabilitative services are necessary to restore or improve lost function caused by a medical condition, and habilitative services are used to establish skills that were never developed due to a medical condition.

Rehabilitative or habilitative services are subject to an annual limit, which may be increased for rehabilitative services required for treatment of a neurologic condition (e.g., stroke, spinal cord or head injury, pediatric neurodevelopmental problems) when the criteria for additional services are met. To receive this additional benefit, prior authorization must be obtained before the initial sessions have been exhausted. A session is one visit. No more than one session of each type of physical, occupational or speech therapy is covered in one day. Limits apply separately to rehabilitative and habilitative services. Medically necessary outpatient services for mental health and chemical dependency are not subject to these limits.

Outpatient rehabilitative services are short term in nature with the expectation that the member's condition will improve in a reasonable and generally predictable period of time. Therapy performed to maintain a current level of functioning without documentation of improvement is considered maintenance therapy and is not covered. Maintenance programs that prevent regression of a condition or function are not covered. This benefit does not cover recreational or educational therapy, educational testing or training, non-medical self-help or training, or hippotherapy.

8.4.3 Infusion Therapy

The Plan covers infusion therapy services and supplies when prior authorized and ordered by a professional provider as a part of an infusion therapy regimen. For some medications, authorization may be limited to select home infusion providers or provider office infusion only. When authorization is limited to select home infusion providers or provider office, infusion therapy administered at a hospital outpatient facility or other in-network provider may not be covered. See section 8.9.6 for self-administered infusion therapy.

Infusion therapy benefits are limited to the following:

a. aerosolized pentamidine
b. intravenous drug therapy

c. total parenteral nutrition
d. hydration therapy
e. intravenous/subcutaneous pain management
f. terbutaline infusion therapy
g. SynchroMed pump management
h. intravenous bolus/push medications
i. blood product administration

In addition, covered expenses include only the following medically necessary services and supplies. Some services and supplies are not covered if they are billed separately. They are considered included in the cost of other billed charges.

a. solutions, medications, and pharmaceutical additives
b. pharmacy compounding and dispensing services
c. durable medical equipment for the infusion therapy
d. ancillary medical supplies
e. nursing services associated with
    i. patient and/or alternative care giver training
    ii. visits necessary to monitor intravenous therapy regimen
    iii. emergency services
    iv. administration of therapy
f. collection, analysis, and reporting of the results of laboratory testing services required to monitor response to therapy

8.4.4 Diagnostic Procedures

The Plan covers diagnostic services, including x-rays and laboratory tests, psychological and neuropsychological testing, and other diagnostic procedures related to treatment of a medical or mental health condition.

The Plan covers all standard imaging procedures related to treatment of a medical condition. Some advanced imaging services require prior authorization (see section 5.1), including the following:

a. Radiology, such as MR procedures (including MRI and MRA), CT, PET, nuclear medicine
b. Cardiac imaging
c. Ultrasound, including maternity ultrasound

A full list of diagnostic services requiring prior authorization is available on the Moda Health website or by contacting Customer Service.

8.4.5 Radium, Radioisotopic, X-ray Therapy, and Kidney Dialysis

Covered expenses include:

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

8.4.6 Outpatient Chemical Dependency Services

Services for assessment and treatment of chemical dependency in an outpatient treatment program that meets the definitions in the Plan (see Section 7) are covered. Behavioral Health

Customer Service can help members locate in-network providers and understand the chemical dependency benefits.

8.4.7 Routine Costs in Clinical Trials

Routine costs for the care of a member who is enrolled in or participating in an approved clinical trial are covered. Routine costs mean medically necessary conventional care, items or services covered by the Plan if typically provided absent a clinical trial. Such costs will be subject to the applicable cost sharing if provided in the absence of a clinical trial.

Approved clinical trials are limited to those:

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 United States Department of Energy, the United States Department of Defense or the United States Department of Veterans Affairs
b. Conducted as an investigational new drug application, an investigational device exemption or a biologics license application to the United States Food and Drug Administration
c. Exempt by federal law from the requirement to submit an investigational new drug application to the United States Food and Drug Administration

The Plan does not cover items or services:

a. That are not covered by the Plan if provided outside of the clinical trial, including the drug, device or service being tested
b. Required solely for the provision or clinically appropriate monitoring of the drug, device or service being tested in the clinical trial
c. Provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the member
d. Customarily provided by a clinical trial sponsor free of charge to any person participating in the clinical trial

Participation in a clinical trial must be prior authorized by Moda Health.

8.5 PROFESSIONAL PROVIDER SERVICES

All professional provider services must be medically necessary in order to be covered.

8.5.1 Preventive Healthcare

As required under the Affordable Care Act (ACA), certain services will be covered at no cost to the member when performed by an in-network provider (see section 4.1 for benefit level when services are provided out-of-network). Moda Health will use reasonable medical management techniques to determine coverage limitations where permitted by the ACA. This means that some alternatives in the services listed below may be subject to member cost sharing:

a. Evidence-based services rated A or B by the United States Preventive Services Taskforce (www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/)

b. Immunizations recommended by the Advisory Committee on Immunization Practices of the Center for Disease Control and Prevention (ACIP)(www.cdc.gov/vaccines/acip/recs/)
c. Preventive care and screenings recommended by the Health Resources and Services Administration for infants, children, adolescents, and women (women's services: www.hrsa.gov/womensguidelines/)

If one of these organizations adopts a new or revised recommendation, the Plan has up to one year before coverage of the related services must be available and effective.

Members may call Customer Service to verify if a preventive service is covered at no cost sharing or visit the Moda Health website for a list of preventive services covered at no cost sharing as required by the ACA. Other preventive services are subject to the applicable cost sharing when not prohibited by federal law. Some frequently used preventive healthcare services covered by the Plan are:

a. Preventive Health Exams. Covered according to the following schedule:

   i. Newborn: one hospital visit
   ii. Infants: 6 well-baby visits during the first year of life
   iii. Age 1 to 4: 7 exams
   iv. Age 5 and above: one exam every year

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

   Routine diagnostic x-ray and lab work related to a preventive health exam that is not required by the ACA is to the standard cost sharing.

b. Immunizations. Routine immunizations for members of all ages, limited to those recommended by the ACIP. Immunizations for the sole purpose of travel or to prevent illness that may be caused by a work environment are not covered.

c. Newborn Hearing Screening. Screening for hearing loss in newborn infants.

d. Routine Vision Screening. Screening to detect amblyopia, strabismus and defects in visual acuity in children age 3 to 5.

e. Preventive Women's Healthcare. One preventive women's healthcare visit per year, including pelvic and breast exams and a Pap test.

   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. Pap tests and breast exams, and mammograms for the purpose of diagnosis in symptomatic or designated high risk women, are also covered when deemed necessary by a professional provider. These services are covered under the office visit, x-ray or lab test benefit level if not performed for preventive purposes.

f. Routine Prostate Rectal Exam & Prostate Specific Antigen (PSA) Test. PSA test is subject to the standard cost sharing. For men age 50 and over, the Plan covers one rectal examination and one PSA test every year or as determined by the treating professional provider. For men younger than 50 years of age who are at high risk for prostate cancer, including African-American men and men with a family medical history of prostate cancer, prostate rectal exam and PSA test are covered as determined by the treating professional provider.

g. Colorectal Cancer Screening. The following services, including related charges, for members age 50 and over:

   i. One flexible sigmoidoscopy and pre-surgical exam or consultation every 5 years
   ii. One colonoscopy, including polyp removal, and pre-surgical exam or consultation every 10 years
   iii. One double contrast barium enema every 5 years
   iv. One fecal occult blood test every year

   These screening timelines align with the USPSTF recommendations for individuals not at high risk for colorectal cancer. Screening procedures performed more frequently must be determined medically necessary.

   Anesthesia that is medically necessary to perform the above preventive services will be covered under the preventive benefit. If the anesthesia is determined not medically necessary, the service is not covered.

   Colorectal cancer screening is covered at no cost sharing when a member meets the criteria in the USPSTF recommendation for colorectal cancer screening. When a member's situation does not fit the USPSTF A or B rated recommendation for colorectal cancer screening, benefits will be at the medical benefit level. If the member has a positive result on a fecal occult blood test covered under the preventive benefit, a follow-up colonoscopy will be covered under the preventive benefit.

   For members who are at high risk for colorectal cancer, including those with a family medical history of known genetic disorders that predispose them to a high lifetime risk of colorectal cancer (such as Lynch syndrome), a prior occurrence of colorectal cancer or an adenomatous polyp, or a personal history of inflammatory bowel disease, colorectal cancer screening exams and laboratory tests are covered as recommended by the treating in-network professional provider and are paid at the medical benefit level if outside the criteria for the USPSTF A or B rated recommendation.

8.5.2 Home, Office or Hospital Visits (including Urgent Care visits)

A visit means the member is actually examined by a professional provider. Covered expenses include naturopath office visits, consultations with written reports, and second opinion surgery consultations.

8.5.3 Contraception

All FDA approved contraceptive methods and counseling are covered when prescribed by a professional provider. Women's contraception, when delivered by an in-network provider and utilizing the most cost-effective option (e.g., generic instead of brand name), will be covered with no cost sharing.

8.5.4 Diabetes Services

Covered medical services for diabetes screening and management include HbA1c lab test and checking for kidney disease. An annual dilated eye exam or retinal imaging is also covered, including one performed by an optometrist or ophthalmologist. Information regarding coverage of diabetic related supplies is in sections 8.6.8 and 8.9.

The Plan covers diabetes self-management programs related to the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and noninsulin-using diabetes when prescribed by a professional provider legally authorized to prescribe such programs. The Plan covers one diabetes self-management program of assessment and training after diagnosis. When there is a material change of condition, medication or treatment, the Plan will also cover up to 3 hours per year of assessment and training if provided by either of the following:

a. A physician, a registered nurse, a nurse practitioner, a certified diabetes educator or a licensed dietitian with demonstrated expertise in diabetes
b. Through an education program credentialed or accredited by a state or national entity accrediting such programs

Services, medications and supplies for management of diabetes from conception through 6 weeks postpartum are covered at no cost sharing. The member or provider must contact Customer Service for this maternal diabetes benefit.

8.5.5 Nutritional Therapy

Dietary or nutritional therapy is covered for certain conditions. Benefits are provided under the diabetes self-management benefit (section 8.5.4) or for management of inborn errors of metabolism (section 8.5.13) excluding obesity. Nutritional therapy for eating disorders requires authorization after the first 5 visits. Preventive nutritional therapy that may be required under the Affordable Care Act is covered under the preventive care benefit.

8.5.6 Therapeutic Injections

Administrative services for therapeutic injections, such as allergy shots, are covered when given in a professional provider's office. When comparable results can be obtained safely with self-administered medications at home, the administrative services for therapeutic injections by the provider are not covered. Vitamin and mineral injections are not covered unless medically necessary for treatment of a specific medical condition. Additional information is in sections 8.8.1 and 8.9.6.

8.5.7 Surgery

Surgery (operative and cutting procedures), including treatment of fractures, dislocations and burns, is covered. The surgery cost sharing level applies to the following services:

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

8.5.8 Circumcision

Circumcision for a newborn is covered when performed within 3 months of birth and may be performed without prior authorization. A circumcision beyond age 3 months must be medically necessary and requires prior authorization.

8.5.9 Reconstructive Surgery Following a Mastectomy

The Plan covers reconstructive surgery following a covered mastectomy:

a. All stages of 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
d. Treatment of physical complications of the mastectomy, including lymphedemas
e. Inpatient care related to the mastectomy and post-mastectomy services

This coverage will be provided in consultation with the member's attending physician and will be subject to the Plan's terms and conditions, including the prior authorization and cost sharing provisions.

8.5.10 Cosmetic and Reconstructive Surgery

Cosmetic surgery is surgery that improves or changes appearance without restoring impaired body function. Reconstructive surgery is surgery performed on abnormal structures of the body, caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease. It is usually performed to improve function, but may also be performed to approximate a normal appearance.

Cosmetic surgery is not covered. All reconstructive procedures, including surgical repair of congenital deformities, must be medically necessary and prior authorized or benefits will not be paid. Reconstructive procedures that are partially cosmetic in nature may be covered if the procedure is medically necessary. This includes services for treatment of a covered mental health condition, such as gender dysphoria.

Treatment for complications related to a surgery performed to correct a functional disorder is covered when medically necessary. Treatment for complications related to a surgery that does not correct a functional disorder is excluded, except for stabilization of emergency medical conditions.

Surgery for breast augmentation, achieving breast symmetry, and replacing breast implants (prosthetics) to accomplish an alteration in breast contour or size are not covered, except as provided in section 8.5.9.

8.5.11 Gender Dysphoria Services

Expenses for gender dysphoria treatment are covered when the following conditions are met:

a. Procedures must be performed by a qualified professional provider
b. Prior authorization is required for surgical procedures
c. Treatment plan must meet medical necessity criteria

Covered services include:

a. Mental health
b. Hormone therapy (including puberty suppression therapy for adolescents)
c. Surgical procedures:
    i. Breast/chest surgery for female-to-male (FtM)
    ii. Gonadectomy (hysterectomy/oophorectomy for FtM or orchiectomy for MtF)
    iii. Single stage or multiple stage reconstruction of the genitalia

8.5.12 Cochlear Implants

Cochlear implants are covered when medically necessary and prior authorized.

8.5.13 Inborn Errors of Metabolism

Inborn errors of metabolism are related to a missing or abnormal gene at birth that affects the metabolism of proteins, carbohydrates and fats. The Plan covers treatment for inborn errors of metabolism for which standard methods of diagnosis, treatment and monitoring exist, including quantification of metabolites in blood, urine or spinal fluid, or enzyme or DNA confirmation in tissues. Coverage includes diagnosing, monitoring and controlling the disorders by nutritional and medical assessment, including but not limited to clinical visits, biochemical analysis and medical foods used in the treatment of such disorders.

8.5.14 Pediatric Dental Care

Dental care is covered for members through the end of the month in which they reach age 19. Services may be subject to frequency or other limits as required under the Affordable Care Act. Examples of the most commonly used services available under this benefit include:

Preventive and diagnostic

a. Dental checkups once every 6 months
b. Cleaning, including periodontal maintenance, covered once in any 6-month period
c. Only the following x-rays are covered: complete series or panoramic once in any 5-year period, bitewing once in any 12-month period, periapical and occlusal
d. Topical application of fluoride covered once in any 6-month period
e. Sealants are covered for unrestored occlusal surfaces of permanent molars once per tooth in a 5-year period

Other dental services

Including fillings, extractions, periodontic and endodontic services, crowns, dentures, general anesthesia and emergency services. Frequency or other limits apply to some services.

a. Space maintainers are covered for missing posterior primary teeth once per space
b. Tooth colored restorations in posterior teeth are considered optional services. Benefits are limited to the amount paid for a metallic restoration. The member is responsible for paying the difference, which is a non-covered charge
c. Orthodontia is covered for treatment of cleft palate with or without cleft lip
d. Athletic mouthguards are covered once in any 12-month period under age 16 and once in any 24-month period age 16 and over

Contact Customer Service for more information about dental services.

8.5.15 Dental Injury

Dental services for members age 19 and up are not covered, except for treatment of accidental injury to natural teeth. Natural teeth are teeth that grew/developed in the mouth. All the following are required to qualify for coverage:

a. The accidental injury must have been caused by a foreign object or was caused by acute trauma (e.g., a broken tooth resulting from biting and/or chewing is not an accidental injury)

b. Diagnosis is made within 6 months of the date of injury
c. Treatment is performed within 12 months of the date of injury
d. Treatment is medically necessary and is provided by a physician or dentist while the member is covered by this policy
e. Treatment is limited to that which will restore teeth to a functional state

Exceptions to the timelines may be made when medically necessary. Implants and implant related services are not covered.

8.5.16 Facility Charges for Dental Procedures

General anesthesia services and related facility charges are covered for a dental procedure performed in a hospital or ambulatory surgical center if medically necessary for members who are physically or developmentally disabled or who have a medical condition that would place the member at undue risk if the dental procedure were performed in a dental office.

8.5.17 Maxillofacial Prosthetic Services

The Plan covers maxillofacial prosthetic services necessary for restoration and management of head and facial structures that cannot be replaced with living tissue and that are defective because of disease, trauma or birth and developmental deformities. Such restoration and management must be performed to control or eliminate infection or pain, or to restore facial configuration or functions such as speech, swallowing or chewing. Cosmetic procedures to improve on the normal range of conditions are not covered.

8.5.18 Alternative Care

Alternative care is spinal manipulation and acupuncture services. To be covered, alternative care must be within the scope of the professional provider's license. It also must not be specifically excluded under the Plan. Chiropractic and acupuncture services to treat musculoskeletal diagnoses must be prior authorized.

There is an annual maximum for alternative care services. Reimbursement and visit limits for other services, such as office visits, lab and diagnostic x-rays, and physical therapy services, are under the Plan's standard benefit for the type of service provided. When there are different copayment levels for alternative care and associated services, only the copayment with the highest cost sharing will apply per visit by the same provider in addition to any applicable coinsurance. Office visits by chiropractors, acupuncturists and naturopathic physicians are considered specialist office visits unless they are credentialed as primary care providers.

8.5.19 Applied Behavior Analysis

Medically necessary applied behavior analysis for autism spectrum disorder (including the symptoms formerly designated as pervasive developmental disorder) and the management of care provided in the member's home, a licensed health care facility or other setting as approved by Moda Health, is covered. Prior authorization and submission of an individualized treatment plan are required.

Coverage for applied behavior analysis does not include:

a. Services provided by a family or household member
b. Custodial or respite care, equine assisted therapy, creative arts therapy, wilderness or adventure camps, music therapy, neurofeedback, chelation or hyperbaric chamber

c. Services provided under an individual education plan in accordance with the Individuals with Disabilities Education Act (20 USC 1400 et seq)
d. Services provided by the Department of Human Services or Oregon Health Authority, other than employee benefit plans offered by the Department and the Authority

8.5.20 Mental Health

The Plan covers medically necessary outpatient services, other than diagnostic testing, by a mental health provider. Intensive outpatient treatment requires prior authorization. See Section 7 for definitions. Behavioral Health Customer Service can help members locate in-network providers and understand the mental health benefits. See section 8.4.4 for coverage of diagnostic services.

8.5.21 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.

8.5.22 Podiatry Services

Covered for the diagnosis and treatment of a specific current problem. Routine podiatry services are not covered unless otherwise required by the member's medical condition (e.g., diabetes).

8.5.23 Tobacco Cessation

Expenses incurred when a member participates in a tobacco cessation program are covered at no cost sharing. Covered expenses include counseling, office visits, medical supplies, and medications provided or recommended by a tobacco cessation program or other professional provider.

A tobacco cessation program means a professional provider offering an overall treatment program that follows the United States Public Health Service guidelines for tobacco use cessation. Members will get the best benefit by using a preferred tobacco cessation program, and may contact Customer Service to locate one.

8.5.24 Telemedicine

Covered medical services, when generally accepted healthcare practices and standards determine they can be safely and effectively provided using synchronous 2-way interactive video conferencing, are covered when provided by an in-network provider using such conferencing. The application and technology used must meet all state and federal standards for privacy and security of protected health information. Benefits are subject to the applicable cost sharing for the covered medical services. Out-of-network telemedicine is not covered.

If telemedicine is in connection with covered treatment of diabetes, communication can also be delivered via audio, Voice over Internet Protocol, or transmission of telemetry. One of the participants must be a representative of an academic health center.

8.6 OTHER SERVICES

All services must be medically necessary in order to be covered.

8.6.1 Ambulance Transportation

Ambulance transportation, including local ground transportation by state certified ambulance and certified air ambulance transportation, is covered for medically necessary transport to the nearest facility that has the capability to provide the necessary treatment. Out-of-network providers may bill members for charges in excess of the maximum plan allowance.

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

8.6.2 Hospice Care

a. Definitions

Hospice means a private or public hospice agency or organization approved by Medicare and accredited by a nationally recognized entity such as The Joint Commission.

Home health aide means 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 treatment plan means a written plan of care established and periodically reviewed by a member's attending physician. The physician must certify in the plan that the member is terminally ill and the plan must describe the services and supplies for medically necessary or palliative care to be provided by the approved hospice.

The Plan covers the services and supplies listed below when included in a hospice treatment plan. Services must be for medically necessary or palliative care provided by an approved hospice agency to a member who is terminally ill and not seeking further curative treatment for the terminal illness.

b. Hospice Home Care

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

i. Registered or licensed practical nurse
ii. Physical, occupational or speech therapist
iii. Home health aide
iv. Licensed social worker

c. Hospice Inpatient Care

The Plan covers short term hospice inpatient services and supplies.

d. Respite Care

The Plan covers respite care (as defined in Section 7) provided to a member who requires continuous assistance when arranged by the attending professional provider and prior authorized. Benefits are for a limited number of days of covered care for services provided in the most appropriate setting. The services and charges of a non-professional provider may be covered for respite care if Moda Health approves.

e. Exclusions

In addition to exclusions listed in Section 9, the following are not covered:

i. Hospice services provided to other than the terminally ill member, including out-of-network bereavement counseling for family members
ii. Services and supplies not included in the hospice treatment plan or not specifically listed as a hospice benefit
iii. Services and supplies in excess of the stated limitations

8.6.3 Maternity Care

Pregnancy care, childbirth and related conditions, including elective abortions, are covered when rendered by a professional provider. Professional providers do not include midwives unless they are licensed and certified. The Plan covers facility charges for maternity care when provided at a covered facility, including a birthing center.

Home birth expenses are not covered other than the fees billed by a professional provider. Additional information regarding home birth exclusions is in Section 9. Supportive services, such as physical, emotional and information support to the mother before, during and after birth and during the postpartum period, are not covered expenses.

Special Right Upon Childbirth (Newborns' and Mothers' Health Protection Act) Benefits for any hospital length of stay in connection with childbirth will not be restricted to less than 48 hours following a normal vaginal delivery or 96 hours following a cesarean section unless the mother's or newborn's attending professional provider, after consulting with the mother, chooses to discharge the mother or her newborn earlier. Prior authorization is not required for a length of stay up to these limits.

8.6.4 Breastfeeding Support

Comprehensive lactation support and counseling is covered during pregnancy and/or the breastfeeding period. The Plan covers the purchase or rental charge (not to exceed the purchase price) for a breast pump and equipment. Charges for supplies such as milk storage bags and extra ice packs, bottles or coolers are not covered. Hospital grade pumps are covered when medically necessary.

8.6.5 Transplants

The Plan covers medically necessary and appropriate transplant procedures that conform to accepted medical practice and are not experimental or investigational.

a. Definitions

Authorized transplant facility means a healthcare facility with which Moda Health has contracted and arranged to provide facility transplant services.

Donor costs means the covered expense of removing the tissue from the donor's body and preserving or transporting it to the site where the transplant is performed as well as any other necessary charges directly related to locating and procuring the organ.

Transplant means a procedure or a series of procedures by which:

i. 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)
ii. tissue is removed from one's body and later reintroduced back into the body of the same person

Corneal transplants and the collection and/or transfusion of blood or blood products are not considered transplants for the purposes of this section and are not subject to this section's requirements.

b. Prior Authorization. Prior authorization should be obtained as soon as possible after a member has been identified as a possible transplant candidate. To be valid, prior authorization approval must be in writing from Moda Health.

c. Covered Benefits. Benefits for transplants are limited as follows:

i. Transplant procedures must be performed at an authorized transplant facility. If an authorized transplant facility cannot provide the necessary type of transplant, Moda Health will prior authorize services at an alternative transplant facility.

ii. Donor costs are covered as follows:

A. If the recipient or self-donor is enrolled in this policy, donor costs related to a covered transplant, including expenses for an enrolled donor resulting from complications and unforeseen effects of the donation, are covered.

B. If the donor is enrolled in this policy and the recipient is not enrolled, the Plan will not pay any benefits toward donor costs.

C. If the donor is not enrolled in this policy, expenses that result from complications and unforeseen effects of the donation are not covered.

iii. Travel and housing expenses for the recipient and one caregiver are covered up to a maximum per transplant.

iv. Professional provider transplant services are paid according to the benefits for professional providers.

v. Immunosuppressive drugs provided during a hospital stay are paid as a medical supply. Outpatient oral and self-injectable prescription medications for transplant related services are paid under the Pharmacy Prescription benefit (section 8.9).

vi. The Plan will not pay for chemotherapy with autologous or homogenic/allogenic bone marrow transplant for treatment of any type of cancer not approved for coverage.

8.6.6 Biofeedback

Covered expenses for biofeedback therapy services are limited to treatment of tension or migraine headaches or urinary incontinence. Covered visits are subject to a lifetime limit.

8.6.7 Home Healthcare

Home healthcare services and supplies are covered when provided by a home healthcare agency for a member who is homebound. Homebound means that the member's condition creates a general inability to leave home. If the member does leave home, the absences must be infrequent, of short duration, and mainly for receiving 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 the member's home.

The home healthcare benefit consists of medically necessary intermittent home healthcare visits. Home healthcare services must be ordered by a physician and be provided by and require the training and skills of one of the following professional providers:

a. Registered or licensed practical nurse
b. Physical, occupational, speech or respiratory therapist
c. Licensed social worker

Home health aides do not qualify as a home health service provider.

This benefit does not include home healthcare, home care services, and supplies provided as part of a hospice treatment plan. These are covered under sections 8.6.2 and 8.6.8.

Out-of-network home health visits are subject to an annual limit. There is a 2-visit maximum in any one day for the services of a registered or licensed practical nurse. All other types of home healthcare providers are limited to one visit per day.

8.6.8 Supplies, Appliances and Durable Medical Equipment

Supplies

Includes:

a. Medical supplies used in a professional provider's office
b. Application of a cast
c. Supplies related to a colostomy or mastectomy
d. Pumps and meters for diabetes

Prosthetic and orthotic devices

Including repair or replacement. Devices must be medically necessary to restore or maintain the ability to complete activities of daily living or essential job-related activities. Prosthetic and orthotic devices that are solely for comfort or convenience are not covered.

The first extremity prosthesis after loss of a body part is covered, including artificial eyes and post-mastectomy bra and prosthetic. An additional prosthesis may be authorized if the attending physician provides documentation to Moda Health that a new prosthetic device is medically necessary because of changing fit or poor function. Testicular prostheses are not covered.

A wig is covered once per year when necessary for hair loss resulting from chemotherapy or radiation therapy.

Appliances

Items, including orthopedic braces, used for performing or facilitating the performance of a particular bodily function. Within 90 days following cataract surgery, one conventional intraocular lens is covered for each eye operated on. Glasses or contact lenses are only covered for the diagnoses of aphakia or keratoconus.

The following are not covered: dental appliances and braces, supporting devices such as corsets, compression or therapeutic stockings except when such stockings are medically necessary, hearing aids except as stated in section 8.6.9, eyeglasses and contact lenses except as otherwise covered by the plan (above and section 8.6.10).

Orthopedic shoes

Covered if they are an integral part of a leg brace or if they are ordered by a professional provider and are medically necessary to restore or maintain the ability to complete activities of daily living or essential job related activities. If such correction or support is accomplished by modification of a mass-produced shoe, then the covered expense is limited to the cost of the modification. The covered expense will not include the original cost of the shoe. Orthopedic shoes or modifications are not covered if they are solely for comfort or convenience.

Durable medical equipment (DME)

Equipment and related supplies that are used primarily to serve a medical purpose, are not generally useful to a member in the absence of a medical condition, are appropriate for use in

the member's home and are designed to withstand repeated use. Examples of DME include a wheelchair, a hospital-type bed and oxygen.

The Plan covers the rental charge (not to exceed the purchase price) for DME. Upon request, members must authorize any supplier furnishing DME to provide information related to the equipment order and any other records Moda Health requires to approve a claim payment. Purchase or maintenance expenses of a wheelchair (including scooters) are subject to a coverage limit.

Replacement or repair
Only covered if the appliance, prosthetic, equipment or DME was not abused, was not used beyond its specifications and not used in a manner to void applicable warranties.

Exclusions
In addition to the exclusions listed in Section 9, the Plan will not cover the following appliances and equipment, even if they relate to a condition that is otherwise covered:

a. Those used primarily for comfort, convenience or cosmetic purposes
b. Those used for education or environmental control (examples of Supportive Environmental materials can be found in Section 9)
c. Therapeutic devices, except for transcutaneous nerve stimulators
d. Incontinence supplies

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

8.6.9 Hearing Aids

The following items are covered once every 48 months:

a. One hearing aid per hearing impaired ear
b. Ear molds
c. Initial batteries, cords and other necessary supplementary equipment
d. Warranty
e. Repairs, servicing or alteration of the hearing aid equipment

The hearing aid must be prescribed, fitted and dispensed by a licensed audiologist or hearing aid specialist with the approval of a licensed physician.

Routine hearing exams for a hearing aid are not covered.

8.6.10 Pediatric Vision Services

The Plan covers one complete eye exam, including refraction, and corrective lenses and frames or contact lenses in lieu of eyeglasses per year for members through the end of the month in which they reach age 19. Members may choose any licensed ophthalmologist or optometrist for these services, and glasses may also be provided by any licensed optician. Extra charges for special purpose vision aids or fashion features are not covered.

8.6.11 Nonprescription Enteral Formula for Home Use

The Plan covers nonprescription elemental enteral formula for home use. The formula must be medically necessary and ordered by a physician for the treatment of severe intestinal malabsorption and must comprise the sole source, or an essential source, of nutrition.

8.7 ACCIDENT BENEFIT

Services and supplies received as treatment for an accidental injury that occurs while a member is covered will be at no cost share to a maximum per accident when completed within 90 days following the injury. Standard cost sharing applies after reaching the dollar maximum or after 90 days, whichever comes first. Accidental injury does not include damage caused by routine or normal body movements such as stooping, twisting, bending or chewing and does not include any condition related to pregnancy or services provided as a result of over-exertion or muscle strains.

8.8 MEDICATIONS

All medications must be medically necessary in order to be covered.

8.8.1 Medication Administered by Provider, Infusion Center or Home Infusion

A medication that is given by injection or infusion (intravenous administration) and is required to be administered in a professional provider's office, infusion center or home infusion is covered at the same benefit level as supplies and appliances (see section 4.1). See section 8.4.3 for more information about infusion therapy and prior authorization requirements. Self-administered medications are not covered under this benefit (see section 8.9.6). See section 8.9 for pharmacy benefits.

8.8.2 Anticancer Medication

Prescribed anticancer medications, including oral, intravenous (IV) or injected medications, are covered. Most anticancer medications may require prior authorization and be subject to specific benefit limitations. Self-administered medications require delivery by an exclusive specialty pharmacy (see section 8.9.6). For some anticancer medications, members may be required to enroll in programs to ensure proper medication use and/or reduce the cost of the medication. More information is available on myModa or by contacting Customer Service.

8.9 PHARMACY PRESCRIPTION BENEFIT

Prescription medications provided when a member is admitted to the hospital are covered by the medical plan as an inpatient expense; the prescription medications benefit described here does not apply.

8.9.1 Definitions

Brand Medications. A brand medication is sold under a trademark and protected name.

Brand Substitution. Both generic and brand medications are covered. If a member requests, or the treating professional provider prescribes, a brand medication when a generic equivalent is available, the member may be responsible for the brand cost sharing plus the difference in cost between the generic and brand medication.

Brand Tier Medications. Brand medications, including specialty brand medications, have been reviewed by Moda Health and do not have significant therapeutic advantage over their preferred alternative(s). These products generally have safe and effective options available under the Value, Select and/or Preferred tiers.

Formulary. A formulary is a listing of all prescription medications and their coverage under the pharmacy prescription benefit. A prescription price check tool is available on myModa under the pharmacy tab. This online formulary tool provides coverage information, treatment options and price estimates.

Generic Medications. Generic medications have been determined by the Food and Drug Administration (FDA) to be therapeutically equivalent to the brand alternative and are the most cost effective option. Generic medications must contain the same active ingredients as their brand counterpart and be identical in strength, dosage form and route of administration.

Legend Medications are those that include the notice "Caution - Federal law prohibits dispensing without prescription".

Over the Counter (OTC) Medications. An over the counter medication is a medication that may be purchased without a professional provider's prescription. OTC designations for specific medications vary by state. Moda Health follows the federal designation of OTC medications to determine coverage.

Preferred Tier Medications. Preferred medications, including specialty preferred medications, have been reviewed by Moda Health and found to be safe and clinically effective at a favorable cost when compared to other medications in the same therapeutic class and/or category. Generic medications may be included in this tier when they have not been shown to be safer or more effective than other more cost effective generic medications.

Preferred Medication List. The Moda Health Preferred Medication List is available on myModa. It provides information about the coverage of commonly prescribed medications and is not an all-inclusive list of covered products. Medications that are new to the market are subject to review and may be subject to additional coverage limitations established by Moda Health.

The preferred medication list and the tiering of medications are subject to change and will be periodically updated. A prescription price check tool is available on myModa under the pharmacy tab. Members with any questions regarding coverage should contact Customer Service.

Moda Health bears no responsibility for any prescribing or dispensing decisions. These decisions are to be made by the professional provider and pharmacist using their professional judgment. Members should consult their professional providers about whether a medication from the preferred list is appropriate for them. This list is not meant to replace a professional provider's judgment when making prescribing decisions.

Select Tier Medications. Select medications include those generic medications that are safe and effective, and represent the most cost effective option within their therapeutic category, as well as certain brand medications that have been identified as favorable from a clinical and cost effective perspective.

Self-Administered Medications. Prescription medications labeled by the FDA for self-administration, which can be safely administered by the member or the member's caregiver outside of a medically supervised setting (such as a physician's office, infusion center or hospital). These medications do not usually require a licensed medical provider to administer them.

Specialty Medications. Certain prescription medications are defined as specialty products. Specialty medications are often used to treat complex chronic health conditions. Specialty treatments often require special handling techniques, careful administration and a unique ordering process. Specialty medications may require prior authorization.

Value Tier Medications. Value medications include commonly prescribed products used to treat chronic medical conditions, and that are considered safe, effective and cost-effective to alternative medications. A list of value tier medications is available on myModa.

8.9.2 Covered Expenses

A covered expense is a charge that meets all of the following criteria:

a. It is for a covered medication supply that is prescribed for a member
b. It is incurred while the member is eligible under the policy
c. The prescribed medication is not excluded

8.9.3 Covered Medication Supply

Includes the following:

a. A legend medication that is medically necessary for treatment of a medical condition
b. Compounded medications containing at least one covered medication as the main ingredient
c. Insulin and diabetic supplies including insulin syringes, needles and lancets, glucometers and test strips, with a valid prescription
d. Select prescribed preventive medications required under the Affordable Care Act
e. Medications for treating tobacco dependence, including OTC nicotine patches, gum or lozenges from an in-network retail pharmacy available with no cost sharing as required under the Affordable Care Act and with a valid prescription
f. Legend contraceptive medications and devices for birth control (section 8.5.3) and medical conditions covered under the policy. Each contraceptive can be dispensed up to a 3-month supply at the initial fill and up to 12-month supply for subsequent fills. Contact Customer Service for information on obtaining a 12-month supply.
g. Select immunizations and related administration fees are covered with no cost sharing at in-network retail pharmacies (e.g. flu, pneumonia and shingles vaccines)

Certain prescription medications and/or quantities of prescription medications may require prior authorization (see section 5.1). Some medications that are often used to treat complex chronic health conditions must be dispensed through an exclusive specialty pharmacy provider. For assistance coordinating prescription refills, contact Pharmacy Customer Service.

Requests for formulary exceptions can be made by the member or professional provider through myModa or by contacting Customer Service. Formulary exceptions and coverage determinations must be based on medical necessity. The prescribing professional provider's contact information must be submitted, as well as information to support the medical necessity, including all of the following:

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

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

8.9.4 Mail Order Pharmacy

Members have the option of obtaining prescriptions for covered medications through an exclusive mail order pharmacy. A mail order pharmacy form can be obtained on myModa or by contacting Customer Service.

8.9.5 Specialty Services and Pharmacy

Specialty medications are often used to treat complex chronic health conditions. The member's pharmacist and other professional providers will advise a member if a prescription requires prior authorization or delivery by an exclusive specialty pharmacy. Information about the clinical services and a list of eligible specialty medications is available on myModa or by contacting Customer Service.

Specialty medications must be prior authorized. If a member does not purchase these medications at the exclusive specialty pharmacy, the expense will not be covered. Some specialty prescriptions may have shorter day supply coverage limits. For some specialty medications, members may be required to enroll in programs to ensure proper medication use and/or reduce the cost of the medication. More information is available on myModa or by contacting Customer Service.

8.9.6 Self-Administered Medication

All self-administered medications are subject to the prescription medication requirements of section 6.10. Self-administered specialty medications are subject to the same requirements as other specialty medications (section 8.9.5).

Self-administered injectable medications are not covered when supplied in a provider's office, clinic or facility.

8.9.7 Step Therapy

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

8.9.8 Limitations

To ensure appropriate access to medications, the following limitations apply:

a. New FDA approved medications are subject to review and may be subject to additional coverage requirements or limits established by the Plan. A member or prescriber can request a medical necessity evaluation if a newly approved medication is initially denied during the review period
b. If a brand medication is dispensed when a generic equivalent is available, the member may be responsible for the difference in cost between the generic and brand medication. Expenses incurred due to brand substitution do not accrue to the out-of-pocket maximum.
c. Establishing therapy, whether by the use of free samples or otherwise, does not waive the Plan's utilization management requirements (e.g., step therapy, prior authorization) before Plan benefits are available.
d. Some specialty medications that have been determined to have a high discontinuation rate or short durations of use may be limited to a 15-day supply
e. Medications with dosing intervals beyond the Plan's maximum day supply will be assessed an increased copayment consistent with the day supply.
f. Claims for medications purchased outside of the United States and its territories will only be covered in emergency and urgent care situations
g. Early refill of medications for travel outside of the United States is subject to review, and when allowed, is limited to once every 6 months. A refill under this provision will not cover a medication supply beyond the end of the plan year.

8.9.9 Exclusions

In addition to the exclusions listed in Section 9, the following medication supplies are not covered:

a. **Devices.** Including but not limited to therapeutic devices and appliances. Information for contraceptive devices is in section 8.9.3 and for other devices in section 8.6.8
b. **Experimental or Investigational Medications.** Including any medication used for an experimental or investigational purpose, even if it is otherwise approved by the federal government or recognized as neither experimental nor investigative for other uses or health conditions
c. **Foreign Medication Claims.** Medications purchased from non-U.S. mail order or online pharmacies or U.S. mail or online pharmacies acting as agents of non-U.S. pharmacies
d. **Hair Growth Medications**
e. **Immunization Agents for Travel**
f. **Institutional Medications.** To be taken by or administered to a member while he or she is a patient in a hospital, rest home, skilled nursing facility, extended care facility, nursing home or similar institution
g. **Medication Administration.** A charge for administration or injection of a medication, except for select immunizations at in-network pharmacies
h. **Medications Covered Under Another Benefit.** Such as medications covered under home health, medical, etc.
i. **Medications Not Approved by FDA.** Products not recognized or designated as FDA approved medications
j. **Non-Covered Condition.** A medication prescribed for purposes other than to treat a covered medical condition
k. **Nutritional Supplements and Medical Foods**

l. **Off-label Use.** Medications prescribed for or used for non-FDA approved indications, unless approved by the Health Evidence Review Commission (ORS 414.688) or the Pharmacy Therapeutics and Review Committee (ORS 414.353).
m. **Over the Counter (OTC) Medications** and prescription medications for which there is an OTC equivalent or alternative, except for those treating tobacco dependence
n. **Repackaged Medications**
o. **Replacement Medications and/or Supplies**
p. **Weight Loss Medications**

SECTION 9. GENERAL EXCLUSIONS

In addition to the limitations and exclusions described elsewhere in this policy, the following services, supplies (including medications), procedures and conditions are not covered, even if otherwise medically necessary, if they relate to a condition that is otherwise covered by the Plan, or if recommended, referred, or provided by an in-network provider. Any direct complication or consequence that arises from these exclusions will not be covered, except for emergency medical conditions.

Benefits Not Stated
Services and supplies not specifically described in this policy as covered expenses

Care Outside the United States
Scheduled care or care that is not due to an urgent or emergency medical condition

Charges Over the Maximum Plan Allowance

Comfort and First-Aid Supplies
Including but not limited to footbaths, vaporizers, electric back massagers, footpads, heel cups, shoe inserts, band-aids, cotton balls, cotton swabs, and off-the-shelf wrist, ankle or knee braces. Related exclusion is under Supportive Environmental Materials

Cosmetic Procedures
Any procedure or medication requested for the purpose of improving or changing appearance without restoring impaired body function, including hormone treatment, rhinoplasty, breast augmentation, lipectomy, liposuction and hair removal (including electrolysis and laser). Exceptions are provided for reconstructive surgery if medically necessary and not specifically excluded (e.g., mastectomy, section 8.5.9).

Court Ordered Sex Offender Treatment

Custodial Care
Routine care and hospitalization that helps a member with activities of daily living, such as bathing, dressing and getting in and out of bed. Custodial care includes care that is primarily for the purpose of keeping a member safe or for holding a member awaiting admission to the appropriate level of care.

Dental Examinations and Treatment; Orthodontia
Except as specifically provided for in sections 8.5.14, 8.5.15 and 8.5.17, or if medically necessary to restore function due to craniofacial anomaly

Educational Items
Including books, tapes, pamphlets, subscriptions, videos and computer games (software)

Enrichment Programs
Psychological or lifestyle enrichment programs including educational programs, assertiveness training, marathon group therapy, and sensitivity training unless provided as a medically necessary treatment for a covered medical condition

Experimental or Investigational Procedures
Including expenses incidental to or incurred as a direct consequence of such procedures (see definition of experimental/investigational in Section 7)

Faith Healing

Family Planning
Surgery to reverse elective sterilization procedures (vasectomy or tubal ligation) and any men's contraceptive that can be legally dispensed without a prescription

Financial Counseling Services

Food Services
Meals on Wheels and similar programs

Guest Meals in a Hospital or Skilled Nursing Facility

Hearing Aids
Except as specifically provided for in section 8.6.9

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

Homemaker or Housekeeping Services

Illegal Acts, Riot or Rebellion, War
Services and supplies for treatment of a medical condition caused by or arising out of a member's voluntary participation in a riot or arising directly from the member's illegal act. This includes any expense caused by, arising out of or related to declared or undeclared war, including civil war, martial law, insurrection, revolution, invasion, bombardment or any use of military force or usurped power by any government, military or other authority

Infertility
All services and supplies for office visits, diagnosis and treatment of infertility, as well as the cause of infertility

Inmates
Services and supplies a member receives while 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.

Legal Counseling

Massage or Massage Therapy

Mental Examination and Psychological Testing and Evaluations
For the purpose of adjudication of legal rights, administrative awards or benefits, corrections or social service placement, employment, or any use except as a diagnostic tool for the treatment of a mental health condition or as specifically provided for in section 8.5.21.

Missed Appointments

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

Necessities of Living
Including but not limited to food, clothing, and household supplies. Related exclusion is under Supportive Environmental Materials

Never Events
Services and supplies related to never events, which are events that should never happen while receiving services in a hospital or facility including 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, which includes serious preventable events

Nuclear Radiation
Any medical condition arising from ionizing radiation, pollution or contamination by radioactivity from any nuclear waste from the combustion of nuclear fuel, and the radioactive, toxic, explosive or other hazardous properties of any explosive nuclear assembly or component, unless otherwise required by law

Nutritional Counseling
Except as provided for in section 8.5.5

Obesity or Weight Reduction
Even if morbid obesity is present. Services and supplies including:

a. Gastric restrictive procedures with or without gastric bypass, or the revision of such procedures
b. Weight management services such as weight loss programs, exercise programs, counseling, hypnosis, biofeedback, neurolinguistic programming, guided imagery, relaxation training and subliminal suggestion used to modify eating behaviors
c. Any medication or formula related to or resulting from the treatment of weight loss or obesity even if prescribed by a physician

The Plan covers services and supplies that are necessary for the treatment of established medical conditions that may be caused by or made worse by obesity, but services and supplies that do so by treating the obesity directly are not covered, except as required under the Affordable Care Act.

Orthopedic Shoes
Except as provided in section 8.6.8

Orthognathic Surgery
Including associated services and supplies

Pastoral and Spiritual Counseling

Personality Disorders

Physical Examinations
Physical examinations for administrative purposes, such as employment, licensing, participating in sports or other activities, or insurance coverage

Physical Exercise Programs

Private Nursing Services

Professional Athletic Events
Diagnosis, treatment and rehabilitation services for injuries sustained while practicing for or participating in a professional (full time, for payment or under sponsorship) or semi-professional (part time, for payment or under sponsorship) athletic contest or event

Psychoanalysis or Psychotherapy
As part of an educational or training program, regardless of diagnosis or symptoms

Reports and Records
Including charges for the completion of claim forms or treatment plans

Routine Foot Care
Including the following services unless otherwise required by the member's medical condition (e.g., diabetes):

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

School Services
Educational or correctional services or sheltered living provided by a school or half-way house

Self-Administered Medications
Including oral and self-injectable, when provided directly by a physician's office, facility or clinic instead of through the prescription medication or anticancer benefits (sections 8.9 and 8.8.2)

Self Help Programs

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

Services Otherwise Available
Including those services or supplies:

a. for which payment could be obtained in whole or in part if a member had applied for payment under any city, county, state or federal law, except for Medicaid coverage
b. for which a member cannot be held liable because of an agreement between the provider and another third party payer which has paid or is obligated to pay for such service or supply

c. for which no charge is made, or for which no charge is normally made in the absence of insurance
d. a member could have received in a hospital or program operated by a government agency or authority. This exclusion does not apply to:
    i. covered services provided at any hospital owned or operated by the state of Oregon or any state approved community mental health and developmental disabilities program
    ii. veterans of the armed forces, in which case covered services and supplies furnished by the Veterans' Administration of the United States and that are not service related are eligible for payment according to the terms of the Plan

Services Provided or Ordered by a Relative
Other than services by a dental provider. Relatives, for the purpose of this exclusion, include a member or a spouse or domestic partner, child, sibling, or parent of a member or his or her spouse or domestic partner.

Services Provided by Volunteer Workers

Sexual Dysfunctions of Organic Origin
Services for sexual dysfunctions of organic origin, including impotence and decreased libido. This exclusion does not extend to sexual dysfunction diagnoses listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders.

Support Education
Including:
a. Level 0.5 education-only programs
b. Education-only, court mandated anger management classes
c. Family education or support groups, except as required under the Affordable Care Act

Supportive Environmental Materials
Including hand rails, ramps, bath benches, humidifiers, air filters, air conditioners, heat lamps, tanning lights, whirlpools, hot tubs, and telephones, and other items that are not for the treatment of a medical condition even if they relate to a condition otherwise covered by the policy. Related exclusion is under Necessities of Living

Taxes

Telehealth
Including telephone visits or consultations and telephone psychotherapy, except telemedicine as specifically provided for in section 8.5.24

Telephones and Televisions in a Hospital or Skilled Nursing Facility

Temporomandibular Joint Syndrome (TMJ)
Services and supplies related to the treatment of TMJ

Therapies
Services or supplies related to hippotherapy (horse therapy), and maintenance therapy and programs

Third Party Liability Claims
Services and supplies for treatment of a medical condition for which a third party is or may be responsible, to the extent of any recovery received from or on behalf of the third party (see section 12.4.2)

Toupees, Hair Transplants

Transportation
Except medically necessary ambulance transport

Treatment in the Absence of Illness
Including individual or family counseling or treatment for marital, behavioral, family, occupational or religious problems, treatment for at risk individuals in the absence of illness or a diagnosed mental health or chemical dependence condition, or treatment of normal transitional response to stress

Treatment After Coverage Terminates
Except for covered hearing aids ordered before coverage terminates and received within 90 days of the end date

Treatment Not Medically Necessary
Including services or supplies that are:

a. Not medically necessary for the treatment or diagnosis of a condition otherwise covered by the Plan or are prescribed for purposes other than treating disease
b. Inappropriate or inconsistent with the symptoms or diagnosis of a member's condition
c. Not established as the standard treatment by the medical community in the service area in which they are received
d. Primarily rendered for the convenience of a member or a provider
e. Not the least costly of the alternative supplies or levels of service that can be safely provided to a member

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.

Treatment Prior to Enrollment
Including services and supplies for an admission to a hospital, skilled nursing facility or other facility that began before the member's coverage in this policy began. Moda Health will provide coverage only for those covered expenses incurred on or after the member's effective date under the policy.

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 as otherwise provided under the policy. See section 8.5.4 for coverage of annual dilated eye exam for management of diabetes.

Vision Surgery
Any procedure to cure or reduce myopia, hyperopia or astigmatism. Includes reversals or revisions of any such procedures and any complications of these procedures.

Vitamins and Minerals
Unless medically necessary for treatment of a specific medical condition and only if they 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.

Work Related Conditions
Treatment of a medical condition arising out of or in the course of employment or self-employment for wages or profit, unless the expense is denied as not work related under any workers' compensation provision. A claim must be filed for workers' compensation benefits and a copy of the workers' compensation denial letter must be submitted for payment to be considered. This exclusion does not apply to owners, partners or executive officers if they are exempt from workers' compensation laws and no workers' compensation coverage is provided to them.

SECTION 10. ELIGIBILITY

If this is a child only plan, coverage is only available to age 26 and dependent children, spouses, and domestic partners of the subscriber are not covered. Disregard any reference to spouses, domestic partners or children. Siblings of the subscriber are eligible, and new siblings would be effective on the date of birth or adoption or placement for adoption.

A person cannot be covered by more than one Moda Health individual medical policy at any time.

10.1 SUBSCRIBER

To be a subscriber, a person must be a resident in the service area and reside in the service area for at least 6 months out of the calendar year. Resident means a person who lives in the service area, and intends to live in the service area permanently or indefinitely. Coverage is not available to a person who is enrolled on a Medicare plan or who resides in the service area for the primary purpose of obtaining health coverage.

10.2 DEPENDENTS

A subscriber's legal spouse or domestic partner is eligible for coverage. A subscriber's children are eligible until their 26th birthday. Foster children are eligible only while legally a foster child.

For purposes of determining eligibility, the following are considered "children":

a. The biological, adopted, or foster child of a subscriber or a subscriber's spouse or domestic partner
b. Children placed for adoption with a subscriber. Adoption paperwork must be provided
c. A newborn child of an enrolled dependent for the first 31 days of the newborn's life
d. Children related to a subscriber by blood or marriage for whom the subscriber is the legal guardian. A court order showing legal guardianship must be provided

A subscriber's child who has sustained a disability rendering him or her physically or mentally incapable of self-support at even a sedentary level may be eligible for coverage even though he or she is over 26 years old. To be eligible, the child must be unmarried and principally dependent on the subscriber for support and have had continuous medical coverage. The incapacity must have arisen, and the information below must be received, before the child's 26th birthday. Social Security Disability status does not guarantee coverage under this provision. Moda Health will determine eligibility based on commonly accepted guidelines. To avoid a break in coverage, it is recommended that the following information be submitted to Moda Health at least 45 days before the child's 26th birthday:

a. Recent medical or psychiatric progress notes and evaluations, referrals, or consult notes
b. Relevant test results (e.g., lab, imaging, neuro-psychiatric testing, etc.)
c. Relevant recent hospitalization records (e.g., history and physical, discharge summary)
d. Disability information from prior carrier

Moda Health will make an eligibility determination based on documentation of the child's medical condition. Periodic review by Moda Health will be required on an ongoing basis except in cases where the disability is certified to be permanent.

10.3 NEW DEPENDENTS

If a subscriber marries or registers a domestic partnership while enrolled in this policy, the spouse or domestic partner and his or her children may be added to this policy by submitting a complete and signed application.

A member's newborn child will be enrolled for 31 days after birth. Adopted children will be enrolled for 31 days from the date of the adoption decree. If a child is placed with the subscriber as a foster child, or pending the completion of adoption proceedings and the subscriber has assumed and retained a legal obligation for full or partial support of the child in anticipation of adoption, that child will be enrolled for the first 31 days from the date of placement. When a premium increase is required, an application and payment must be submitted within 60 days. If payment is required but not received, the child will not be covered. The child may only be added subsequently at the next open enrollment. Proof of legal guardianship will be required for coverage of a grandchild beyond the first 31 days from birth. When there is no premium change, members should still submit a completed application to ensure the child is enrolled and payment of claims will not be delayed.

A new dependent may cause a premium increase. Premiums will be adjusted accordingly and will apply during the first 31 days of coverage for newborn or adopted children.

10.4 ELIGIBILITY AUDIT

Moda Health reserves the right to conduct audits to verify a member's eligibility, and may request documentation including but not limited to medical and certain financial records and birth certificates, adoption paperwork, marriage certificates, domestic partner registration, proof of residency and any other evidence necessary to document eligibility on the Plan.

SECTION 11. ENROLLMENT

A complete and signed application must be submitted for persons to be enrolled in the policy. Moda Health must be notified whenever there is a change of address.

11.1 ENROLLING NEW DEPENDENTS

A subscriber may obtain coverage for newly acquired or newly eligible dependents by submitting an application and supporting documentation (e.g., marriage or birth certificate, placement or adoption paperwork, etc.) within 60 days of their eligibility. The subscriber must notify Moda Health if family members are added or dropped from coverage, even if it does not affect premiums.

11.2 OPEN ENROLLMENT PERIODS

Persons can apply for coverage during the open enrollment period. For 2018, open enrollment is from November 1 to December 15, 2017. These dates may be different in future years.

11.3 SPECIAL ENROLLMENT PERIODS

Persons can apply for coverage or enroll in another individual plan within 60 days from the following qualifying events:

a. Loss of minimum essential coverage due to loss of eligibility, but not as a result of voluntary termination of coverage (except for termination of a non-calendar year plan on the last day of the plan year), non-payment of premium or rescission
b. Loss of coverage under Medicaid or a state child health plan
c. Obtaining new dependents through marriage, domestic partner registration, birth, adoption or placement for adoption or foster care
d. Child support order or other court order requiring coverage of a dependent
e. Becoming enrolled or disenrolled as a result of the error, misrepresentation or inaction of the Marketplace and its agents, or of the U.S. Department of Health and Human Services (HHS)
f. Having adequate evidence that there is a violation of a material provision made by the qualified health plan (QHP) in which he or she is enrolled
g. Decertification of the QHP in which he or she is enrolled
h. Becoming eligible or newly ineligible for advanced payments of the premium tax credit
i. Having a change in eligibility for cost sharing reductions
j. Moving permanently to a new location with access to new QHPs
k. Having other exceptional circumstances in accordance with guidelines issued by HHS

In the case of the loss of minimum essential coverage, permanent move to new area with different QHP option, or when a person covered on a group plan becomes newly eligible for advance payments of the premium tax credit due to being ineligible for qualifying coverage on the group plan, a person has 60 days before or after the event to enroll.

11.4 PREMIUMS

The current premium amount is shown either on the declaration page that comes with this policy or any subsequent premium change notice.

11.4.1 Making Payments

Premium payments are due monthly for continued coverage. Payments can be made by check, cash, money order or prepaid debit card with a billing statement, or by electronic fund transfer (EFT). If a subscriber no longer wishes to pay by EFT, Moda Health must be notified in writing 15 days before the next deduction date. For other changes in billing option, Moda Health must receive 30 days prior written notice from the subscriber. Electronic billing (eBill) is also available, allowing subscribers to pay the monthly premium on myModa using their bank account.

Premium payments by third parties are not accepted, except when required by law.

11.4.2 When Payments are Due

All premium payments are due in advance. Moda Health will allow a 10-day grace period after the premium due date. If payment is not received within the grace period, this policy will end after a 10-day advance notice. Coverage will end on the last day of the coverage period for which premiums were paid. If this policy ends because premiums have not been paid, Moda Health may require payment of any unpaid past-due premiums from the last 12 months before open enrollment or special enrollment coverage under a new Moda Health policy becomes effective.

This policy is renewed each time a subscriber makes a timely premium payment.

11.4.3 Changes in Amount of Premiums

Moda Health can change the amount of the premiums without notice when there is a change in the family composition, county of residence or eligibility status. The premium change will take effect the first of the month following the event. When a member moves into the next age bracket of the rate table, premiums will change on the renewal date. Thirty days written notice will be provided before a change in the premiums affecting all policyholders takes effect. When the new premium is paid, the payment will confirm the subscriber's acceptance of the change.

11.5 WHEN COVERAGE BEGINS

Coverage for new applicants begins on the 1st day of the month following receipt of the application if the application is received from the 1st to the 15th of a month, or the 1st of the second month if the application is received from the 16th to the last day of the month, unless another month is selected.

Coverage for a newborn is effective on the date of the newborn's birth. Coverage for a child newly adopted or placed for adoption or as a foster child is effective on the date of adoption or placement. For new spouses or domestic partners coverage begins on the 1st of the month following receipt of the application.

Coverage begins for persons who qualify due to the loss of minimum essential coverage and apply on or before the loss of coverage on the 1st of the month following the loss of coverage. When there is a court order or military discharge, coverage begins the effective date of the order or the

date of discharge. Coverage for those enrolling during open enrollment begins on the date the policy renews.

In all cases, the required premium must also be paid for coverage to become effective.

11.6 WHEN COVERAGE ENDS

When the subscriber's coverage ends, coverage for all enrolled dependents also ends.

11.6.1 Termination by Subscriber

A subscriber may terminate his or her coverage, or coverage for any enrolled dependent, by giving Moda Health 30 days prior written notice. Coverage ends on the last day of the month through which premiums are paid.

11.6.2 If Moda Health Refuses to Renew

Under certain circumstances (described in section 14.10), Moda Health can refuse to renew this policy at the end of any period for which premiums are paid.

11.6.3 Rescission

Moda Health may rescind a member's coverage back to the effective date, or deny claims at any time, for fraud or intentional material misrepresentation. This may include but is not limited to enrolling ineligible persons in the policy, falsifying or withholding documentation or information that is the basis for eligibility, and falsification or alteration of claims. Moda Health reserves the right to retain premiums paid as liquidated damages, and the member shall be responsible for the full balance of any benefits paid. A member will be notified of a rescission 30 days prior to cancellation of coverage.

11.6.4 Death

If the subscriber dies, coverage for all enrolled dependents ends on the last day of the month in which the death occurs. Enrolled dependents may convert to coverage in their own names by filing a written application with Moda Health and paying the required premium within 60 days after eligibility under this policy ends.

11.6.5 Loss of Eligibility by Dependent

Coverage ends for an enrolled spouse on the last day of the month in which a decree of divorce or annulment is entered (regardless of any appeal), and for an enrolled domestic partner on the last day of the month in which a judgment of dissolution or annulment of the domestic partnership has been entered. Coverage ends for an enrolled child on the last day of the month in which he or she reaches age 26, except that a foster child's coverage ends on the day of the month in which the legal foster child relationship ends. The subscriber must notify Moda Health when a marriage, domestic partnership or foster child relationship ends.

A former dependent may continue coverage by submitting a complete and signed application under his or her own name and paying the required premium within 60 days after eligibility under this policy ends.

11.6.6 Moving Out of the Service Area

Coverage will terminate if the subscriber no longer resides in the service area.

SECTION 12. CLAIMS ADMINISTRATION & PAYMENT

12.1 SUBMISSION AND PAYMENT OF CLAIMS

In no event, except absence of legal capacity, is a claim valid if submitted later than 12 months from the date the expense was incurred.

Moda Health does not always pay claims in the order in which charges are incurred. This may affect how a member's cost sharing is applied to claims. For example, a deductible may not be applied to the first date a member is seen in a benefit year if a later date of service is paid first.

12.1.1 Hospital and Professional Provider Claims

A member who is hospitalized or visits a professional provider must present his or her Moda Health identification card to the admitting or treating office. In most cases, the hospital or professional provider will bill Moda Health directly for the cost of the services. Moda Health will pay the provider and send copies of its payment record to the member. The provider will then bill the member for any charges that were not covered.

Sometimes a hospital or professional provider will require a member, at the time of discharge or treatment, to pay charges for a service that the provider believes is not a covered expense. If this happens, the member must pay these amounts if he or she wishes to accept the service. Moda Health will reimburse the member if any of the charges paid are later determined to be covered.

When a member is billed by the hospital or professional provider directly, he or she should send a copy of the bill to Moda Health and include all of the following information:

a. Patient's name
b. Subscriber's name and identification number
c. Date of service
d. Diagnosis with corresponding current ICD codes
e. Itemized description of the services and charges with corresponding American Medical Association CPT and/or Centers for Medicare and Medicaid HCPCS codes

If the treatment is for an accidental injury, a statement explaining the date, time, place, and circumstances of the accident must be included with the bill.

For care received outside the United States, see section 12.1.5.

12.1.2 Ambulance Claims

Bills for ambulance service must show where the member was picked up and taken as well as the date of service, the member's name and identification number.

12.1.3 Tobacco Cessation Program Claims

Moda Health will be billed directly by the exclusive tobacco cessation program for the cost of counseling, consultation and supplies. Other providers may require a member to pay the charges and submit a claim to Moda Health. If this happens, the member should submit a request for reimbursement. Prescription tobacco cessation medications follow the process in section 12.1.4. Members should use the claim form specific to the tobacco cessation program for over the

counter medications and other services or supplies that are not prescribed. This form is available on myModa or by contacting Customer Service.

12.1.4 Prescription Medication Claims

Members who go to an in-network pharmacy should present their Moda Health ID card and pay the prescription cost sharing as required by the Plan. There will be no claim to submit.

A member who fills a prescription at an out-of-network pharmacy that does not access Moda Health's claims payment system will need to submit a request for reimbursement by completing the prescription medication claim form, which is available on myModa.

12.1.5 Out-of-Country or Foreign Claims

Out-of-country care is only covered for emergency or urgent care situations. When care is received outside the United States, the member must provide all of the following information to Moda Health:

a. Patient's name, subscriber's name, and group and identification numbers
b. Statement explaining where the member was and why he or she sought care
c. Copy of the medical record (translated is preferred if available)
d. Itemized bill for each date of service
e. Proof of payment in the form of a credit card/bank statement or cancelled check

12.1.6 Explanation of Benefits (EOB)

Moda Health will report its action on a claim by providing the member a document called an Explanation of Benefits (EOB). Members are encouraged to access their EOBs electronically by signing up through myModa. Moda Health may pay claims, deny them, or accumulate them toward satisfying the deductible. If all or part of a claim is denied, the reason will be stated in the EOB.

If a member does not receive an EOB or an email indicating that an EOB is available within a few weeks of the date of service, this may indicate that Moda Health has not received the claim. To be eligible for reimbursement, claims must be received within the claim submission period explained in section 12.1.

12.1.7 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. Moda Health will respond to an inquiry within 30 days of receipt.

12.2 COMPLAINTS, APPEALS AND EXTERNAL REVIEW

12.2.1 Definitions

For purposes of section 12.2, the following definitions apply:

Adverse Benefit Determination means a written notice from Moda Health, in the form of a letter or an Explanation of Benefits (EOB), of any of the following: denial of initial eligibility or rescission of coverage, or a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including one based on a determination of a person's eligibility to participate in the Plan and one resulting from the application of any pre-existing condition exclusion or utilization review, as well as a failure to cover an item or service

for which benefits are otherwise provided because it is determined to be experimental or investigational or not necessary and customary by the standards of generally accepted practice for the prevention or treatment of disease or accidental injury, or when continuity of care is denied because the course of treatment is not considered active. A **Final Internal Adverse Benefit Determination** is an adverse benefit determination that has been upheld by Moda Health at the completion of the internal appeal process or with respect to which the internal appeal process has been exhausted.

Appeal is a written request by a member or his or her representative for Moda Health to review an adverse benefit determination.

Claim involving urgent care means any claim for medical care or treatment in which the application of the regular time period to review a denial of a pre-service claim could seriously jeopardize a member's life or health or ability to regain maximum function, or, in the opinion of a physician with knowledge of a member's medical condition, would subject the member to severe pain that cannot be adequately managed without the requested care or treatment.

Complaint means an expression of dissatisfaction about a specific problem a member has encountered or about a decision by Moda Health or an agent acting on behalf of Moda Health, and which includes a request for action to resolve the problem or change the decision. A complaint does not include a request for information or clarification about any subject related to the policy.

Post-service claim means any claim for a benefit under the Plan for care or services that have already been received by a member.

Pre-service claim means any claim for a benefit under the Plan for care or services that require prior authorization.

Utilization review means a system of reviewing the medical necessity, appropriateness, or quality of medical care services and supplies using specified guidelines, including preadmission certification, the application of practice guidelines, continued stay review, discharge planning, prior authorization of ambulatory procedures, and retrospective review. An adverse benefit determination that the item or service is not medically necessary or appropriate, is investigational or experimental, or in which the decision as to whether a benefit is covered involved a medical judgment is a utilization review decision.

12.2.2 Time Limit for Submitting Appeals

A member has **180 days** from the date of an adverse benefit determination to submit a written appeal. If an appeal is not submitted within this timeframe, the right to the appeal process will be lost.

If the appeal is regarding the termination or reduction of an ongoing course of treatment before the end of the authorized period of time or number of treatments, Moda Health will provide continued coverage pending the outcome. If the decision is upheld, the member is responsible for the cost of coverage received during the review period.

The timelines addressed in the sections below do not apply when the member does not reasonably cooperate, or circumstances beyond the control of either party prevents that party from complying with the standards set (but only if the party who is unable to comply gives notice of the specific circumstances to the other party when the circumstances arise).

12.2.3 Appeals

Before filing an appeal that does not concern initial eligibility, it may be possible to resolve a dispute with a phone call to Customer Service. Otherwise, an appeal must be submitted in writing. If necessary, Customer Service can provide assistance filing an appeal. The member may review the claim file and present evidence and testimony as part of the appeal process, and may appoint a representative to act on his or her behalf. Moda Health will acknowledge receipt of the written appeal within 7 days and conduct an investigation by persons who are not involved in the initial determination.

An appeal related to an urgent care claim will be entitled to expedited review upon request. An expedited review will be completed no later than 72 hours after receipt of the appeal by Moda Health, unless the member fails to provide sufficient information for Moda Health to make a decision. In this case, Moda Health will notify the member within 24 hours of receipt of the appeal of the specific information necessary to make a decision. The member will have 48 hours to provide the specified information. The investigation of an urgent care claim will be completed no later than 48 hours following the earlier of (a) Moda Health's receipt of the specified information, or (b) the end of the period provided to submit the specified additional information.

Investigation of a pre-service appeal will be completed within 15 days. Investigation of a post-service appeal will be completed within 30 days. If new or additional evidence or rationale is used by Moda Health in connection with the claim, it will be provided to the member, in advance and free of charge, before any final internal adverse benefit determination. Members may respond to this information before Moda Health's determination is finalized. Moda Health will send a written notice of the decision to the member, including the basis for the decision, and if applicable, information on the right to request an external review.

12.2.4 External Review

If the dispute meets the criteria below, a member may request that it be reviewed by an independent review organization appointed by the Oregon Division of Financial Regulation.

a. The dispute must relate to an adverse benefit determination based on a utilization review decision; whether a course or plan of treatment that a member is undergoing is an active course of treatment for purposes of continuity of care (see section 12.3); or cases in which Moda Health fails to meet the internal timeline for review or the federal requirements for providing related information and notices
b. The request for external review must be in writing no more than 180 days after receipt of the final internal adverse benefit determination. A member may submit additional information to the independent review organization within 5 days, or 24 hours for an expedited review
c. The member must sign a waiver granting the independent review organization access to his or her medical records
d. The member must have exhausted the appeal process described in section 12.2.3. However, Moda Health may waive this requirement and have a dispute referred directly to external review with the member's consent. For an urgent care claim or when the dispute concerns a condition for which the member received emergency services and is still hospitalized, a request for external review may be expedited or simultaneous with a request for internal appeal review
e. The member shall provide complete and accurate information to the independent review organization in a timely manner

The decision of the independent review organization is binding except to the extent other remedies are available to the member under state or federal law. *If Moda Health fails to comply with the decision, the member may initiate a suit against Moda Health.*

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 a person is a member under the policy does not qualify for external review. A complaint decision does not qualify for external review.

12.2.5 Complaints

Moda Health will investigate complaints regarding the following issues when submitted in writing within 180 days from the date of the claim:

a. Availability, delivery or quality of a healthcare service
b. Claims payment, handling or reimbursement for healthcare services that is not disputing an adverse benefit determination
c. Matters pertaining to the contractual relationship between a member and Moda Health

Investigation of a complaint will be completed within 30 days. If additional time is needed Moda Health will notify the member and have an additional 15 days to make a decision.

12.2.6 Additional Member Rights

Members have the right to file a complaint or seek other assistance from the Oregon Division of Financial Regulation.

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

This information is subject to change upon notice from the Director of the Oregon Division of Financial Regulation.

12.3 CONTINUITY OF CARE

12.3.1 Continuity of Care

Continuity of care allows a member who is receiving care from an individual professional provider to continue care with that professional provider for a limited period of time after the medical services contract terminates.

Moda Health will provide continuity of care if a medical services contract or other contract for a professional provider's services is terminated, the professional provider no longer participates in the network, and the Plan does not cover services when services are provided to members by the professional provider or covers services at a benefit level below the benefit level specified in the Plan for out-of-network professional providers.

Continuity of care requires the individual professional provider to be willing to adhere to the medical services contract that had most recently been in effect between the professional provider and Moda Health, and to accept the contractual reimbursement rate applicable at the

time of contract termination, or if the contractual reimbursement rate was not based on a fee for service, a rate equivalent to the contractual rate.

For a member to receive continuity of care, all of the following conditions must be satisfied:

a. The member must request continuity of care from Moda Health
b. The member is undergoing an active course of treatment that is medically necessary and, by agreement of the professional provider and the member, it is desirable to maintain continuity of care
c. The contractual relationship between the professional provider and Moda Health, with respect to the policy covering the member, has ended

However, Moda Health will not be required to provide continuity of care when the contractual relationship between the professional provider and Moda Health ends under one of the following circumstances:

a. The professional provider has relocated out of the service area or is prevented from continuing care for patients because of other circumstances
b. The contractual relationship has terminated in accordance with provisions of the medical services contract relating to quality of care and all contractual appeal rights of the professional provider have been exhausted

Moda Health will not provide continuity of care if the member is no longer covered by this policy or if the subscriber discontinues the policy in which the member is enrolled.

12.3.2 Length of Continuity of Care

Except in the case of pregnancy, continuity of care will end on the earlier of the following dates:

a. The day following the date on which the active course of treatment entitling the member to continuity of care is completed
b. The 120th day after the date of notification by Moda Health to the member of the termination of the contractual relationship with the professional provider

For a member who is undergoing care for pregnancy and who becomes entitled to continuity of care after commencement of the second trimester of the pregnancy, continuity of care will end on the later of the following dates:

a. The 45th day after the birth
b. As long as the member continues under an active course of treatment, but not later than the 120th day after the date of notification by Moda Health to the member of the termination of the contractual relationship with the professional provider

12.3.3 Notice Requirement

Moda Health will give written notice of the termination of the contractual relationship with a professional provider and of the right to obtain continuity of care to those members that Moda Health knows or reasonably should know are under the care of the professional provider. The notice shall be given to the members no later than the 10th day after the date on which the termination of the contractual relationship takes effect or no later than the 10th day after Moda Health first learns the identity of an affected member after the date of termination of the contractual relationship. If the professional provider belongs to a provider group, the provider

group may deliver the notice if the notice clearly provides the information that Moda Health is required to provide to affected members.

For purposes of notifying a member of the termination of the contractual relationship between Moda Health and the professional provider and the right to obtain continuity of care, the date of notification by Moda Health is the earlier of the date on which the member receives the notice or the date on which Moda Health receives or approves the request for continuity of care.

12.4 BENEFITS AVAILABLE FROM OTHER SOURCES

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

12.4.1 Coordination of Benefits (COB)

This provision applies when a member has healthcare coverage under more than one plan. A complete explanation of COB is in Section 13.

12.4.2 Third Party Liability

A member may have a legal right to recover benefit or healthcare costs from a third party as a result of a medical condition for which such costs were paid by Moda Health. The policy does not cover benefits for which a third party may be legally liable. Because recovery from a third party may be difficult and take a long time, as a service to the member Moda Health will pay a member's expenses based on the understanding and agreement that Moda Health is entitled to be reimbursed in full from any recovery the member may receive for any benefits paid that are or may be recoverable from a third party, as defined below.

The member agrees that Moda Health has the rights described in section 12.4.2. Moda Health may seek recovery under one or more of the procedures outlined in this section. The member agrees to do whatever is necessary to fully secure and protect, and to do nothing to prejudice, Moda Health's right of recovery or subrogation as discussed in this section. Moda Health has discretion to interpret and construe these recovery and subrogation provisions.

12.4.2.1 Definitions:

For purposes of section 12.4.2, the following definitions apply:

Benefits means any amount paid by Moda Health, or submitted for payment to or on behalf of a member. Bills, statements or invoices submitted by a provider to or on behalf of a member are considered requests for payment of benefits by the member.

Recovery Funds means any amount recovered from a third party.

Third Party means any person or entity responsible for the medical condition, or the aggravation of a medical condition, of a member. Third party includes any insurer of such person or entity, including different forms of liability insurance, or any other form of insurance that may pay money to or on behalf of the member including uninsured motorist coverage, under-insured motorist coverage, premises med-pay coverage, personal injury protection (PIP) coverage, and workers' compensation insurance.

Third Party Claim means any claim, lawsuit, settlement, award, verdict, judgment, arbitration decision or other action against a third party (or any right to such an action) by or on behalf of a member.

12.4.2.2 Subrogation

Upon payment by the Plan, Moda Health has the right to pursue the third party in its own name, or in the name of the member. The member shall do whatever is necessary to secure such subrogation rights and do nothing to prejudice them. Moda Health is entitled to all subrogation rights and remedies under common and statutory law, as well as under the policy.

12.4.2.3 Right of Recovery

In addition to its subrogation rights, Moda Health may, at its sole discretion and option, require a member, and his or her attorney, if any, to protect its recovery rights. The following rules apply:

a. The member holds any rights of recovery against the third party in trust for Moda Health, but only for the amount of benefits Moda Health paid for that medical condition.

b. Moda Health is entitled to receive the amount of benefits it has paid for a medical condition out of any settlement or judgment that results from exercising the right of recovery against the third party. This is so whether or not the third party admits liability or claims that the member is also at fault. In addition, Moda Health is entitled to receive the amount of benefits it has paid whether the healthcare expenses are itemized or expressly excluded in the third party recovery.

c. If Moda Health requires the member and his or her attorney to protect its recovery rights under this section, then the member may subtract from the money to be paid back to Moda Health a proportionate share of reasonable attorney fees as an expense for collecting from the other party.

d. This right of recovery includes the full amount of the benefits paid or pending payment by Moda Health, out of any recovery made by the member from the third party, including without limitation any and all amounts from the first dollars paid or payable to the member (including his or her legal representatives, estate or heirs, or any trust established for the purpose of paying for the future income, care or medical expenses of the member), regardless of the characterization of the recovery, whether or not the member is made whole, or whether or not any amounts are paid or payable directly by the third party, an insurer or another source. Moda Health's recovery rights will not be reduced due to the member's own negligence.

e. If it is reasonable to expect that the member will incur future expenses for which benefits might be paid by Moda Health, the member shall seek recovery of such future expenses in any third party claim.

f. In third party claims involving the use or operation of a motor vehicle, Moda Health, at its sole discretion and option, is entitled to seek reimbursement under the personal injury protection statutes of the state of Oregon, including ORS 742.534, ORS 742.536, or ORS 742.538, or under other applicable state law.

12.4.2.4 Additional Provisions

Members shall comply with the following, and agree that Moda Health may do one or more of the following at its discretion:

a. The member shall cooperate with Moda Health to protect its recovery rights, including by:
   i. Signing and delivering any documents Moda Health reasonably requires to protect its rights, including a Third Party Reimbursement Questionnaire and Agreement. If the member has retained an attorney, then the attorney must also sign the agreement. The Plan will not be required to pay benefits until the agreement is properly signed and returned
   ii. Providing any information to Moda Health relevant to the application of the provisions of section 12.4.2, including all information available to the member, or any representative or attorney representing the member, relating to the potential third party claim. This may include medical information, settlement correspondence, copies of pleadings or demands, and settlement agreements, releases or judgments
   iii. Notifying Moda Health of the potential third party claim for which the Plan may issue benefits. The member has this responsibility even if the first request for payment of benefits is a bill or invoice submitted to Moda Health by the member's provider
   iv. Taking such actions as Moda Health may reasonably request to assist it in enforcing its third party recovery rights

b. The member and his or her representatives are obligated to notify Moda Health in advance of any claim (written or oral) and/or any lawsuit made against a third party seeking recovery of any damages from the third party, whether or not the member is seeking recovery of benefits paid by Moda Health from the third party.

c. By accepting payment of benefits by the Plan, the member agrees that Moda Health has the right to intervene in any lawsuit or arbitration filed by or on behalf of a member seeking damages from a third party.

d. The member agrees that Moda Health may notify any third party, or third party's representatives or insurers, of its recovery rights described in section 12.4.2.

e. Even without the member's written authorization, Moda Health may release to, or obtain from, any other insurer, organization or person, any information it needs to carry out the provisions of section 12.4.2.

f. Section 12.4.2 applies to any member for whom advance payment of benefits is made by the Plan whether or not the event giving rise to the member's injuries occurred before the member became covered by Moda Health.

g. If the member continues to receive treatment for a medical condition after obtaining a settlement or recovery from a third party, the Plan will provide benefits for the continuing treatment of that medical condition only to the extent that the member can establish that any sums that may have been recovered from the third party have been exhausted.

h. If the member or the member's representatives fail to do any of the above mentioned acts, then Moda Health has the right to not advance payment or to suspend payment of any benefits, or to recover any benefits it has advanced, for any medical condition resulting from the event giving rise to, or the allegations in, the third party claim. Moda Health may notify medical providers seeking authorization of payment of benefits that all payments have been suspended and may not be paid.

i. Coordination of benefits (where the member has healthcare coverage under more than one plan or health insurance policy) is not considered a third party claim.

12.4.3 Surrogacy

Members who enter into a surrogacy agreement must reimburse Moda Health for covered services related to conception, pregnancy, delivery or postpartum care that are received in connection with the surrogacy agreement. The amount the member must pay will not exceed the payments or other compensation she and any other payee is entitled to receive under the surrogacy agreement. Any cost sharing amounts the member pays will be credited toward the amount owed under this section.

By accepting services, the member assigns Moda Health the right to receive payments that are payable to the member or any other payee under the surrogacy agreement, regardless of whether those payments are characterized as being for medical expenses. Moda Health will secure its rights by having a lien on those payments and on any escrow account, trust or other account that holds those payments. Those payments shall first be applied to satisfy Moda Health's lien.

Within 30 days after entering a surrogacy agreement, the member must send written notice of the agreement, a copy of the agreement, and the names, addresses and telephone numbers of all parties involved in the agreement to Moda Health. The member must also complete and send to Moda Health any consents, releases, authorizations, lien forms and other documents necessary for Moda Health to determine the existence of any rights we may have under this section and to satisfy those rights.

If the member's estate, parent, guardian or other party asserts a claim against a third party based on the surrogacy agreement, such person or entity shall be subject to Moda Health's liens and other rights to the same extent as if the member had asserted the claim against the third party.

12.5 MEDICARE

To the extent permitted by law, the Plan will not pay for any part of a covered expense to the extent the expense is actually paid under Medicare Part A or B or would have been paid under Medicare Part B had the member properly enrolled in Medicare and applied for benefits. The Plan will estimate what Medicare would have paid and reduce its benefits based on the estimate. In addition, the Plan does not pay for any part of expenses incurred from providers who have opted out of Medicare participation.

SECTION 13. COORDINATION OF BENEFITS

Coordination of Benefits (COB) occurs when a member has healthcare coverage under more than one plan.

13.1 DEFINITIONS

For purposes of Section 13, the following definitions apply:

Plan means any of the following that provides benefits or services for medical or dental care or treatment. 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 includes:

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

Plan does not include:

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

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.

Complying plan is a plan that complies with these COB rules.

Non-complying plan is a plan that does not comply with these COB rules.

Claim means a request that benefits of a plan be provided or paid.

Allowable expense means a healthcare expense, including cost sharing, that is covered at least in part by any plan covering the member. When a plan provides benefits in the form of a service rather than cash payments, the reasonable cash value of the service will also be considered an allowable expense and a benefit paid. An expense that is not covered by any plan covering the

member is not an allowable expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a member is not an allowable expense.

The following are examples of expenses that are not allowable expenses:

a. The difference between the cost of a semi-private hospital room and a private hospital room, unless one of the plans provides coverage for private hospital room expenses
b. The amount of the reduction by the primary plan because a member has failed to comply with the plan's provisions concerning second surgical opinions or prior authorization, or because the member has a lower benefit due to not using an in-network provider
c. Any amount in excess of the highest reimbursement amount for a specific benefit, if a member is covered by 2 or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology
d. Any amount in excess of the highest of the negotiated fees, if a member is covered by 2 or more plans that provide benefits or services on the basis of negotiated fees
e. If a member is covered by one plan that calculates its benefits on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another plan that provides its benefits on the basis of negotiated fees, the primary plan's arrangement shall be the allowable expense for all plans. However, if the provider has contracted with the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the allowable expense used by the secondary plan to determine its benefits
f. If a plan is advised by a member that all plans covering the member are high-deductible health plans and the member intends to contribute to a health savings account established in accordance with Section 223 of the Internal Revenue Code of 1986, the primary high-deductible health plan's deductible is not an allowable expense, except for any healthcare expense incurred that may not be subject to the deductible as described in Section 223(c)(2)(C)

This Plan is the part of this policy that provides benefits for healthcare expenses to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the policy providing healthcare benefits is separate from this Plan. A policy may apply one COB provision to certain benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

Closed panel plan is a plan that provides healthcare benefits to covered persons primarily in the form of services through a network of providers that have contracted with or are employed by the plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by an in-network provider.

Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

13.2 HOW COB WORKS

If the member is 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 order of benefit determination rules govern the order in which each plan will pay a claim for benefits.

The **primary plan** (the plan that pays benefits first) pays the benefits that would be payable under its terms in the absence of this provision.

The **secondary plan** (the plan that pays benefits after the primary plan) will reduce the benefits it pays so that payments from all plans do not exceed 100% of the total allowable expense.

This Plan will coordinate with a plan that is "excess" or "always secondary" or that uses order of benefit determination rules that are inconsistent with those contained in OAR 836-020-0770 to 836-020-0805 (non-complying plan) on the following basis:

a. If this Plan is primary, it will provide its benefits first
b. If this Plan is secondary and the non-complying plan does not provide its primary payment information within a reasonable time after it is requested to do so, this Plan will assume that the benefits of the non-complying plan are identical to this Plan's benefits. This Plan will provide its benefits first, but the amount of the benefits payable shall be determined as if this Plan were the secondary plan.
c. If the non-complying plan reduces its benefits so that the member receives less in benefits than he or she would have received had this Plan provided its benefits as the secondary plan and the non-complying plan provided its benefits as the primary plan, then this Plan shall advance additional benefits equal to the difference between the amount that was actually paid and the amount that should have been paid if the non-complying plan had not improperly reduced its benefits. Additional payment will be limited so that this Plan will not pay any more than it would have paid if it had been the primary plan. In consideration of such an advance, this Plan shall be subrogated to all rights of the member against the non-complying plan.

13.3 ORDER OF BENEFIT DETERMINATION (WHICH PLAN PAYS FIRST?)

The first of the following rules that applies will govern:

a. **Non-dependent/Dependent**. If a plan covers the member as other than a dependent, for example, an employee, member of an organization, primary insured or retiree, then that plan will determine its benefits before a plan that covers the member as a dependent. However, if the member is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the member as a dependent and primary to the plan covering the member as other than a dependent (e.g. a retired employee), then the order of benefits between the 2 plans is reversed.
b. **Dependent Child/Parents Married or Living Together**. If the member is a dependent child whose parents are married or are living together whether or not they have ever been married or domestic partners, the plan of the parent whose birthday falls earlier in the calendar year is the primary plan. If both parents' birthdays are on the same day, the

plan that has covered the parent the longest is the primary plan. (This is called the birthday rule.)

c. **Dependent Child/Parents Separated or Divorced or Not Living Together**. If the member is a dependent child of divorced or separated parents, or parents not living together whether or not they have ever been married or domestic partners, then the following rules apply:
    i. If a court decree states that one of the parents is responsible for the healthcare expenses of the child, and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to plan years commencing after the plan is given notice of the court decree.
    ii. If a court decree states that both parents are responsible for the healthcare expenses of the child, or that the parents have joint custody without specifying that one parent is responsible, the birthday rule described above applies.
    iii. If there is not a court decree allocating responsibility for the child's healthcare expenses, the order of benefits is as follows: The plan covering the
        A. Custodial parent
        B. Spouse or domestic partner of the custodial parent
        C. Non-custodial parent
        D. Spouse or domestic partner of the non-custodial parent
d. **Dependent Child Covered by Individual Other than Parent**. For a dependent child covered under more than one plan of persons who are not the parents of the child, the first applicable provision (b or c) above shall determine the order of benefits as if those persons were the parents of the child.
e. **Dependent Child Covered by Parent and Spouse**. For a dependent child covered under the plans of both a parent and a spouse, the length of coverage provision below shall determine the order of benefits. If coverage under either or both parents' plans and the spouse's plans began on the same day, the birthday rule will apply.
f. **Active/Retired or Laid Off Employee**. The plan that covers a member as an active employee, that is, one who is neither laid off nor retired (or as that employee's dependent) determines its benefits before those of a plan that covers the member as a laid off or retired employee (or as that employee's dependent). If the other plan does not have this rule, and if as a result the plans do not agree on the order of the benefits, this rule is ignored.
g. **COBRA or State Continuation Coverage**. If a member whose coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the member as an employee, member of an organization, primary insured, or retiree or as a dependent of the same, is the primary plan and the COBRA or other continuation coverage is the secondary plan. If the other plan does not have this rule, and if as a result the plans do not agree on the order of the benefits, this rule is ignored.
h. **Longer/Shorter Length of Coverage**. The plan that covered a member longer is the primary plan and the plan that covered the member for the shorter period of time is the secondary plan.
i. **None of the Above**. If the preceding rules do not determine the order of benefits, the allowable expenses shall be shared equally between the plans. In addition, this Plan will not pay more than it would have paid had it been the primary plan.

13.4 EFFECT ON THE BENEFITS OF THIS PLAN

In determining the amount to be paid for any claim, the secondary plan will calculate the benefits it would have paid in the absence of other healthcare coverage and apply that calculated amount to any allowable expense under its plan that is unpaid by the primary plan. The secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other healthcare coverage.

If the primary plan is a closed panel plan and the member uses an out-of-network provider, the secondary plan shall provide benefits as if it were the primary plan, except for emergency services or authorized referrals that are paid or provided by the primary plan.

13.5 PHARMACY COB

Claims subject to the COB provision of the Plan may be submitted electronically by pharmacies or through the direct member reimbursement paper claim process. The preferred method is for the pharmacy to electronically transmit the primary plan's remaining balance to Moda Health for processing. If approved, the secondary claim will be automatically processed according to plan benefits. Members who are unable to have their secondary claims processed electronically may submit a claim reimbursement request directly to Moda Health (see section 12.1.4).

The manner in which a pharmacy claim is paid by the primary payer will affect how Moda Health pays the claim as the secondary plan.

Denied by Primary: If a claim is denied by the primary plan, Moda Health will process the claim as if it is primary.

Approved by Primary:

Primary plan does not pay anything toward the claim. Reasons for this may include the member has not satisfied a deductible or the cost of the medication is less than the primary plan's cost sharing. In this scenario, Moda Health will pay as if it is primary.

Primary plan pays benefits. In this scenario, Moda Health will pay up to what the Plan would have allowed had it been the primary payer. The Plan will not pay more than the member's total out of pocket expense under the primary plan.

SECTION 14. MISCELLANEOUS PROVISIONS

14.1 DISCLOSURE OF BENEFIT REDUCTION

Moda Health will provide notification of material reductions in covered services or benefits to the subscriber no later than 30 days prior to the adoption of the change (more information in section 14.10).

14.2 RIGHT TO COLLECT AND RELEASE NEEDED INFORMATION

In order to receive benefits, the member must give or authorize a provider to give Moda Health any information needed to pay benefits. Moda Health may release to or collect from any person or organization any needed information about the member.

14.3 CONFIDENTIALITY OF MEMBER INFORMATION

Keeping a member's protected health information confidential is very important to Moda Health. Protected health information includes enrollment, claims, and medical and dental information. Moda Health uses such information internally for claims payment, referrals and authorization of services, and business operations such as case management and quality management programs. Moda Health does not sell this information. The Notice of Privacy Practices provides more detail about how Moda Health uses members' information. A copy of the notice is available on the Moda Health website by following the HIPAA link or by calling 800-852-5195 ext. 5033.

14.4 TRANSFER OF BENEFITS

Only members are entitled to benefits under this policy. These benefits are not assignable or transferable to anyone else. Any attempted assignment or transfer will not be binding on Moda Health, except that Moda Health shall pay amounts due under the Plan directly to a provider when billed by a provider licensed, certified or otherwise authorized by laws in the state of Oregon or upon a member's written request.

14.5 RECOVERY OF BENEFITS PAID BY MISTAKE

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

14.6 CORRECTION OF PAYMENTS

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.

14.7 CONTRACT PROVISIONS

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

14.8 RESPONSIBILITY FOR QUALITY OF MEDICAL CARE

In all cases, members have the exclusive right to choose their provider. Moda Health is not responsible for the quality of medical care a member receives, since all those who provide care do so as independent contractors. Moda Health cannot be held liable for any claim for damages connected with injuries a member suffers while receiving medical services or supplies.

14.9 WARRANTIES

All statements made by the applicant 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 member, a copy of which has been given to the subscriber or member or member's beneficiary.

14.10 GUARANTEED RENEWABILITY

Moda Health is required to renew coverage at the subscriber's option. Medicare eligibility is not a basis for non-renewal of this policy. Coverage may only be discontinued or non-renewed:

a. For nonpayment of the required premiums by the subscriber. (Moda Health will terminate the policy with 10 days' notice if premiums are not received when due)
b. For fraud or misrepresentation by a member
c. When a member is enrolled in Medicare
d. When Moda Health discontinues offering and/or renewing all of its individual health benefit plans in Oregon or in a specified service area within Oregon. Discontinuing a policy under this provision will be administered in accordance with ORS 743B.125

e. When the director orders Moda Health to discontinue coverage in accordance with procedures specified or approved by the director upon finding that the continuation of the coverage would:
    i. Not be in the best interests of its members
    ii. Impair Moda Health's ability to meet its contractual obligations
f. When, in the case of an individual health benefit plan that delivers covered services through a specified network of healthcare providers, the member no longer lives, resides or works in the service area of the provider network and the termination of coverage is not related to the health status of any member
g. When, in the case of a health benefit plan that is offered in the individual market only through one or more bona fide associations, the membership of a person in the association ceases and the termination of coverage is not related to the health status of any member

Moda Health may modify an individual health benefit plan at the time of coverage renewal. The modification is not a discontinuation as described under paragraph (c) of this section.

14.11 NO WAIVER

Any waiver of any provision of this policy or any performance under this policy 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 Moda Health delays or fails to exercise any right, power or remedy provided in this policy, including a delay or omission in denying a claim, that shall not waive Moda Health's rights to enforce the provisions of the Plan.

14.12 COMPLIANCE WITH FEDERAL AND STATE MANDATES

Moda Health provides benefits in accordance with the requirements of all applicable state and federal laws and as described in this policy. This includes coverage of essential health benefits as defined by the Affordable Care Act and compliance with federal mental health parity requirements.

14.13 GOVERNING LAW

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

14.14 WHERE ANY LEGAL ACTION MUST BE FILED

Any legal action arising out of this policy must be filed in either state or federal court in the state of Oregon.

14.15 TIME LIMIT FOR FILING A LAWSUIT

Any legal action arising out of, or related to, this policy and filed against Moda Health by a member or any third party must be filed in court no more than 3 years after the time the claim was filed (see section 12.1). All internal levels of appeal under the Plan must be exhausted before filing a legal action in court.

14.16 EVALUATION OF NEW TECHNOLOGY

Moda Health develops medical necessity criteria for new technologies and new use of current technologies. The technology 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.

SECTION 15. PATIENT PROTECTION ACT

The intent of the Patient Protection Act is to assure, among other things, that patients and providers are informed about their health benefit plans.

15.1 What are members' rights and responsibilities?

Members have the right to:

a. Be treated with respect and recognition of their dignity and need for privacy
b. Have access to urgent and emergency services, 24 hours a day, 7 days a week
c. Know what their rights and responsibilities are. Members will be given information about the Plan and how to use it, and about the providers who will care for them. This information will be provided in a way that members can understand.
d. Participate in decision making regarding their healthcare. This includes a discussion of appropriate or medically necessary treatment options for their conditions, whether or not the cost or benefit is covered by Moda Health, and the right to refuse care and to be advised of the medical result of their refusal.
e. Receive services as described in this policy
f. Have their medical and personal information remain private. Personal information will be handled in compliance with state and federal law, and will be given to third parties only as necessary to administer the Plan, as required by law, or as permitted by the member
g. Change to a new primary care physician (PCP)
h. File a complaint or appeal about any aspect of the Plan, and to receive a timely response. Members are welcome to make suggestions to Moda Health.
i. Obtain free language assistance services, including verbal interpretation services, when communicating with Moda Health
j. Have a statement of wishes for treatment, known as an Advanced Directive, on file with their professional providers. Members also have the right to file a power of attorney, which allows a member to give someone else the right to make healthcare choices when the member is unable to make these decisions.
k. Make suggestions regarding Moda Health's policy on members' rights and responsibilities

Members have the responsibility to:

a. Read this policy to make sure they understand the policy. Members are advised to call Customer Service with any questions.
b. Select a PCP for those plans that require it
c. To the extent required by the Plan, seek medical services only from their PCP
d. Obtain approval from their PCP before going to a specialist
e. Treat all providers and their staff with courtesy and respect
f. Provide all the information needed for their provider to provide good healthcare
g. Participate in making decisions about their medical care and forming a treatment plan
h. Follow instructions for care they have agreed to with their provider
i. Use urgent and emergency services appropriately
j. Present their medical identification card when seeking medical care
k. Notify providers of any other insurance policies that may provide coverage
l. Reimburse Moda Health from any third party payments they may receive
m. Keep appointments and be on time. If this is not possible, members must call ahead to let the provider know they will be late or cannot keep the appointment

n. Seek regular health checkups and preventive services
o. Provide adequate information to Moda Health to properly administer benefits and resolve any issues or concerns that may arise

Members may call Customer Service with any questions about these rights and responsibilities.

15.2 What if a member has a medical emergency?

A member who believes he or she has a medical emergency should call 911 or seek care from the nearest appropriate provider, such as a physician's office or clinic, urgent care facility or emergency room.

A member does not need to contact his or her PCP prior to seeking emergency treatment. However, the member should contact the PCP as soon as reasonably possible after seeking emergency care.

15.3 How will a member know if benefits are changed or terminated?

Moda Health will notify members of any benefit changes through the mail. Members may also find their current benefits on myModa or contact Customer Service about their benefits.

15.4 Will a member be informed if the PCP is no longer participating in the network?

If a member's PCP ends his or her participation in the network, Moda Health will inform the member and provide instructions on how to change the PCP.

15.5 If a member is not satisfied with the Plan, how can an appeal be filed?

A member can file an appeal by contacting Customer Service or by writing a letter to Moda Health. Complete information is available in section 12.2.

A member may also contact the Oregon Division of Financial Regulation

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

15.6 What are the prior authorization and utilization review criteria?

Prior authorization is used to determine whether a service is covered (including whether it is medically necessary) before the service is provided. Members may contact Customer Service or visit myModa for a list of services that require prior authorization.

Obtaining prior authorization is the member's assurance that the services and supplies recommended by the provider are medically necessary and covered. Response to a provider request for prior authorization will be within 2 business days. Except in the case of fraud or misrepresentation, prior authorization for benefit coverage and medical necessity shall be binding if obtained no more than 30 days prior to the date the service is provided, and eligibility shall be binding for 5 business days from the date of the authorization.

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

A written summary of information that may be included in Moda Health's utilization review of a particular condition or disease can be obtained by calling Customer Service.

15.7 How are important documents, such as medical records, kept confidential?

Moda Health protects member information in several ways:

a. Moda Health has a written policy to protect the confidentiality of health information
b. Only employees who need to access member information in order 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

15.8 How can a member participate in the development of Moda Health's corporate policies and practices?

Member feedback is very important. Moda Health welcomes any suggestions for improvements to its health benefit plans or services.

Moda Health has formed advisory committees, including the Quality Council for healthcare professionals, to allow participation in the development of corporate policies and to provide feedback. Committee membership is limited. Members may obtain more information by contacting Moda Health.

15.9 How can non-English speaking members get information about the policy?

A representative will coordinate the services of an interpreter over the phone when a member calls Customer Service for assistance.

15.10 What additional information is available upon request?

The following documents are available free of charge by calling Customer Service:

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

15.11 What information about Moda Health is available from the Oregon Division of Financial Regulation?

The following information regarding Moda Health's health benefit plans is available from the Oregon Division of Financial Regulation:

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

Contact:

Oregon Division of Financial Regulation
PO Box 14480, Salem, Oregon 97309-0405
503-947-7984 or toll-free 888-877-4894
dfr.oregon.gov
cp.ins@state.or.us

15.12 What is provider risk sharing?

This plan includes risk sharing arrangements with providers. Under a risk-sharing arrangement, the providers that are responsible for delivering healthcare services are subject to some financial risk or reward for the services they deliver. Contact Moda Health for additional information.

For help, call us directly at 888-393-2940
(En Español: 888-786-7461)

P.O. Box 40384
Portland, OR 97240

modahealth.com

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Moda Health nondiscrimination notice

Moda, Inc. complies with applicable federal civil rights laws. We do not discriminate on the basis of race, color, national origin, age, disability or sex.

Moda provides free, timely aids and services to people with disabilities to help them communicate with us effectively. These accommodations include sign language interpreters and written information in other formats.

If your primary language is not English, Moda also provides free, timely interpretation services and/or materials written in other languages.

If you need any of the services listed above, contact:

Customer Service,
888-217-2363 (TDD/TTY 711)

If you believe that Moda has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a written grievance by mailing or faxing it to:

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

If you need assistance filing a grievance, 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 to:

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).

Office for Civil Rights complaint forms are available at hhs.gov/ocr/office/file/index.html.

Moda's efforts to assure nondiscrimination are coordinated by:

Tom Bikales, VP Legal Affairs
601 SW Second Ave.
Portland, OR 97204
855-232-9111
compliance@modahealth.com

Health plans in Oregon and Alaska provided by Moda Health Plan, Inc. 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. 15019019 (8/16)

DELTA DENTAL
Delta Dental of Oregon & Alaska

moda HEALTH

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

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

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

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

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

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

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

ATANSYON: Si ou pale Kreyòl Ayisyen, nou ofri sèvis gratis pou ede w nan lang ou pale a. Rele nan 1-877-605-3229 (moun ki itilize sistèm TTY rele : 711)

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

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

ATENÇÃO: Caso fale português, estão disponíveis serviços gratuitos de ajuda linguística. Telefone para 1-877-605-3229 (TERMINAL: 711)

ATTENZIONE: Se parla italiano, sono disponibili per lei servizi gratuiti di assistenza linguistica. Chiamare il numero 1-877-605-3229 (TTY: 711)

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

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

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

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

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

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

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

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

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

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