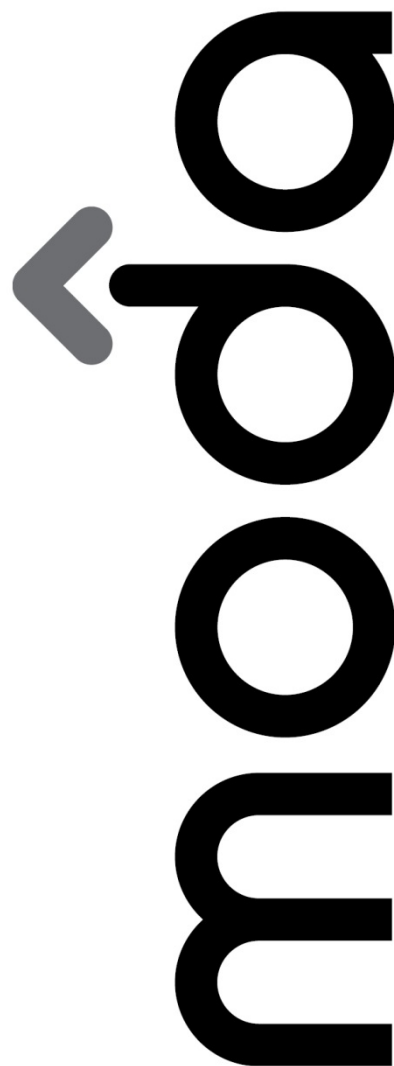


Oregon Individual Policy

Be Lively Plan
Beacon Network
(\$5,500 Deductible Plan)



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

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 Be Lively PPO 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.

1.1 MEMBER RESOURCES

Moda Health Website (log in to **myModa**)
www.modahealth.com

Medical Customer Service Department
Portland 503-265-2964; Toll-free 888-393-2940
En Español 503-265-2961; Llamado gratis 888-786-7461

Behavioral Health Customer Service Department
Portland 503-624-9382; Toll-free 1-800-799-9391

Pharmacy Customer Service Department
Portland 503-243-3960; Toll-free 888-235-8015

Telecommunications Relay Service for the hearing impaired
711

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

Health Insurance Marketplace (the Marketplace)
800-318-2596
www.healthcare.gov

SECTION 2. 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 5.

Section 3.1 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 or a penalty.

2.1 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. 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.

2.1.1 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 in Baker, Benton, Clatsop, Columbia, Coos, Crook, Curry, Deschutes, Douglas, Gilliam, Grant, Harney, Hood River, Jackson, Jefferson, Josephine, Klamath, Lake, Lane, Lincoln, Linn, Malheur, Morrow, Sherman, Tillamook, Umatilla, Union, Wallowa, Wasco and Wheeler counties

Pharmacy Network is Moda Health MedImpact

2.1.2 Coverage Outside the Service Area for Children

Enrolled children residing in the United States but outside the primary service area may receive the in-network benefit level by using a travel network provider as described in section 2.1.3. If a travel network provider is not available, plan benefits will be extended to such children as if the care were rendered by in-network providers, 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

2.1.3 Travel Network

Members traveling outside of the primary service area may receive the in-network benefit level by using a travel network provider. The in-network benefit level only applies to a travel network provider if members are outside the primary service area 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.

Travel Network

PHCS Healthy Directions

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

2.1.4 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.

2.2 SCHEDULE OF BENEFITS

Covered expenses for American Indians and Alaska Natives are at no cost sharing when provided directly through the Indian Health Service, Tribal Clinic, Urban Indian Clinic, or through referral under Contract Health Services.

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

	<u>In-Network Benefits</u>	<u>Out-of- Network Benefits</u>
Annual deductible per member	\$ 5,500	\$11,000
Maximum annual family aggregate deductible	\$11,000	\$22,000
Annual out-of-pocket maximum per member	\$ 6,850	\$13,700
Maximum annual aggregate out-of-pocket maximum per family	\$13,700	\$27,400

Services	Cost Sharing (Deductible applies unless noted differently)		Section in Handbook & Details
	In-network	Out-of-network	
Emergency Care			
Emergency Room Facility	40%	40%	Section 6.3 In-network deductible and out-of-pocket maximum apply to all services.
Hospital and Residential Facility Care			
Inpatient Acute Care	40%	50%	Section 6.4.3

Services	Cost Sharing (Deductible applies unless noted differently)		Section in Handbook & Details
	In-network	Out-of-network	
Inpatient Rehabilitation and Habilitation	40%	50%	Section 6.4.4 30 days per year. May be eligible for up to 60 days for treatment of neurologic conditions (N/A to mental health/chemical dependency)
Skilled Nursing Facility Care	40%	50%	Section 6.4.5 60 days per year
Residential Mental Health & Chemical Dependency Treatment Programs	40%	50%	Section 6.4.6
Chemical Dependency Detoxification	40%	50%	Section 6.4.7
Ambulatory Services			
Outpatient Surgery and Invasive Diagnostic Procedures (Facility Charges)	40%	50%	Section 6.5.1
Outpatient Rehabilitation and Habilitation	\$100 per visit, deductible waived	50%	Section 6.5.2 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)	40%	50%	Section 6.5.3
Diagnostic Procedures, including x-ray and lab	40%	50%	Section 6.5.4
Therapeutic X-ray	40%	50%	Section 6.5.5
Kidney Dialysis	40%	50%	Section 6.5.5
Imaging Procedures	40%	50%	Section 6.5.6
Outpatient Chemical Dependency Services	\$80 per visit, deductible waived	50%	Section 6.5.7
Professional Services			
Preventive Healthcare			Section 6.6.1
Services as required under the Affordable Care Act, including the following:	No cost sharing	50%	
Periodic Health Exams	No cost sharing	50%	7 exams age 1- 4 One per year, age 5+
Immunizations	No cost sharing	50%	

Services	Cost Sharing (Deductible applies unless noted differently)		Section in Handbook & Details
	In-network	Out-of-network	
Newborn Hearing Screening	No cost sharing	50%	
Routine Vision Screening	No cost sharing	50%	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	50%	One per 10 years, age 50+
Routine Diagnostic X-ray & Lab	40%	50%	
Prostate Rectal Exam	40%	50%	One per year, age 50+
Prostate Specific Antigen (PSA) Test	40%	50%	One per year, age 50+
Urgent Care, Home and Office Visits	\$80 per visit, deductible waived	50%	Section 6.6.3 Does not include visits for mental health, chemical dependency, family planning or biofeedback
Specialist Visits (including naturopath visits)	\$100 per visit, deductible waived	50%	Section 6.6.3
Physician Hospital Visits	40%	50%	Section 6.6.3
Outpatient Diabetic Instruction	40%	50%	Section 6.6.4 Once, following diagnosis
Therapeutic Injections	40%	50%	Section 6.6.6
Surgery	40%	50%	Section 6.6.7
Special Dental Care	40%	50%	Section 6.6.13
Alternative Care (Spinal Manipulation, Acupuncture Services, & Naturopathic Substances)	40%, deductible waived	50%	Section 6.6.16 \$1,000 aggregate annual maximum
Applied Behavior Analysis			Section 6.6.18
Office Visits	\$80 per visit, deductible waived	50%	
Other Services	40%	50%	
Outpatient Mental Health Services	\$80 per visit, deductible waived	50%	Section 6.6.19
Tobacco Cessation Treatment			Section 6.6.21 Age 10+
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	40%	40% (in-network deductible and out-of-pocket maximum apply)	Section 6.7.1 6 trips per year
Hospice Care			Section 6.7.2
Home Care	40%	50%	
Inpatient Care	40%	50%	
Respite Care	40%	50%	30 day lifetime maximum, up to 5 days consecutive
Maternity	40%	50%	Section 6.7.3
Breastfeeding Support, Supplies and Counseling	No cost sharing	No cost sharing	Section 6.7.4
Transplants			Section 6.7.5 \$7,500 maximum travel and housing expense per transplant
Exclusive transplant network facilities	40%	N/A	
Other facilities	Not covered	Not covered	
Biofeedback	\$80, deductible waived	50%	Section 6.7.6 10 visits
Home Healthcare	40%	50%	Section 6.7.7 140 out-of-network visits per year
Outpatient Durable Medical Equipment	40%	50%	Section 6.7.8 One wheelchair per year under age 19 and every 3 years age 19+
Supplies and Appliances	40%	50%	Section 6.7.8
Disposable Supplies (provided in a professional provider's office)	40%	50%	Section 6.7.8
Hearing Aids and Related Services	40%	50%	Section 6.7.9 Once every 48 months. For members under age 26
Pediatric Vision Care			Section 6.7.10 Under age 19
Exam	40%, deductible waived	50%	One per year
Lenses & frames or contacts	40%	50%	One pair per year

Services	Cost Sharing (Deductible applies unless noted differently)		Section in Handbook & Details
	In-network	Out-of-network	
Medications			
Anticancer Medication	40%	50%	Section 6.8.2 If purchased at pharmacy, subject to deductible as it applies to pharmacy benefits
Prescription Medication			Section 6.9
Retail and Specialty Pharmacy			Up to 30-day supply per prescription
Value	\$2, deductible waived	\$2, deductible waived	
Select	40%	40%	
Preferred	40%	40%	
Brand	50%	50%	
Specialty	50%	Not covered	
Mail Order Pharmacy			Up to 90-day supply per prescription
Value	\$6, deductible waived	\$6, deductible waived	
Select	40%	40%	
Preferred	40%	40%	
Brand	50%	50%	
Specialty	50%	Not covered	

2.3 DEDUCTIBLES

The Plan has an annual deductible. The deductible amounts are shown in section 2.2, and are the amount of covered expenses that are paid by a member before benefits are payable by the Plan. In-network and out-of-network amounts accumulate separately. After the deductible has been satisfied, benefits will be paid according to section 2.2. When a per member deductible is met, benefits for that member will be paid according to section 2.2. 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.

2.4 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 the following costs (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):

- a. Cost containment penalties
- b. Disallowed charges

2.5 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 3. COST CONTAINMENT

The following special cost containment provisions may affect how benefits are paid.

3.1 PRIOR AUTHORIZATION REQUIREMENTS

When a professional provider suggests admission to the hospital or a residential program, or a non-emergency surgery, the member should ask the provider to contact Moda Health for prior authorization. The hospital, professional provider and member are notified of the outcome of the authorization process by letter.

If a member fails to obtain prior authorization for inpatient or residential stays, or for outpatient or ambulatory services when authorization is required (other than advanced imaging services), a penalty of 50% up to a maximum deduction of \$2,500 per occurrence will be applied to covered charges before regular plan benefits are computed. The member will be responsible for any charges not covered because of noncompliance with authorization requirements.

If prior authorization is not obtained for advanced imaging services for members utilizing all networks other than PHCS, the charges will be denied.

The prior authorization penalty does not apply toward the Plan's deductible or out-of-pocket maximum. The penalty will not apply in the case of an emergency admission.

Prior authorization does not guarantee coverage. When a service is otherwise excluded from benefits, charges will be denied.

A member may obtain authorization information by contacting Customer Service. For mental health or chemical dependency services, contact Behavioral Health Customer Service.

3.1.1 Inpatient Services and Residential Programs

All non-emergency hospital confinements that are scheduled in advance, and admission to any residential treatment program, must be prior authorized in order for maximum plan benefits to be payable. If the hospital or residential stay is not medically necessary, claims will be denied. Moda Health will authorize medically necessary lengths of stay based upon the medical condition. Additional hospital or residential days are covered only upon medical evidence of need.

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).

3.1.2 Ambulatory Surgery and Other Outpatient Services

The Plan requires prior authorization for many outpatient services. Prior authorization must be obtained for any inpatient admission or overnight stay for a service that is commonly performed on an outpatient basis. Some outpatient or ambulatory services also require authorization. Any covered benefit will be based on the cost of the most appropriate setting for the procedure.

In-network providers who perform advanced imaging services are responsible for obtaining prior authorization on the member's behalf. 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. The in-network provider is expected to write off the full charge of the service. If the provider is out-of-network, the full charge will be the member's responsibility.

3.1.3 Prescription Medication

A complete list of medications that require prior authorization is available on myModa or by contacting Customer Service. The member, provider or pharmacy should contact Customer Service for prior authorization.

Prior authorization programs are not intended to create barriers or limit access to medications. Medications 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. Requiring prior authorization ensures member safety, promotes proper use of medications and supports cost effective treatment options for members.

3.2 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.

3.3 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 4. CARE COORDINATION

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.

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.

If calling from Portland area503-948-5561

Outside the Portland area.....800-592-8283

Office Hours – Monday through Friday
7:00 AM to 5:30 PM (Pacific Time)

SECTION 5. 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.

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.

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

Chemical Dependency means an addictive relationship with any drug or alcohol characterized by a physical and/or psychological relationship that interferes on a recurring basis with an individual's social, psychological or physical adjustment to common problems. 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.

Creditable Coverage means a member's prior healthcare coverage, including coverage remaining in force at the time a member obtains new coverage, as defined in 42 US Code §300gg-3(c)(1)

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 also includes care that is primarily for the purpose of separating a member from others, or for preventing a member from harming himself or herself.

Day Treatment or 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.

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. 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 that manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson possessing 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, ancillary tests and medical determinations required to ascertain 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 ancillary 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, such further medical examination and treatment as are required to stabilize a member.

Experimental or Investigational means services and supplies that:

- a. 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
- b. Are not recognized by the medical community in the service area in which they are received
- c. 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
- d. Involve a treatment for which scientific or medical assessment has not been completed, or the effectiveness of the treatment has not been generally established
- e. Are available in the United States only as part of a clinical trial or research program for the illness or condition being treated

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 the manifestation of 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 expense.

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 to provide care to members.

The Marketplace refers to the Health Insurance Marketplace, the federally facilitated entity established to administer the state health insurance exchange program.

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 an out-of-network provider other than a facility is the lesser of supplemental provider fee arrangements Moda Health may have in place and the 75th percentile of fees commonly charged for a given procedure in a given area, based on a national database. If a dollar value is not available in the national database, Moda Health will consider 75% of the billed charge as the MPA. In certain instances, when a dollar value is not available in the national database, the claim is reviewed by Moda Health's medical consultant, who determines a comparable code to the one billed. Once a comparable code is established, the claim is processed as described above.

MPA for out-of-network facilities such as hospitals, ambulatory surgical centers, home health providers, skilled nursing facilities and residential treatment programs is the lesser of supplemental facility or provider fee arrangements Moda Health may have in place, 125% of the Medicare allowable amount based on data collected from the Centers for Medicare and Medicaid Services (CMS), or the billed charge.

MPA for out-of-network end-stage renal disease (ESRD) facilities is 125% of the Medicare allowable amount.

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 medical devices, including implanted devices, and for durable medical equipment is the contracted amount, or the lesser of 100% of the Medicare allowable amount or the acquisition cost of the device plus 10% if there is no contracted 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) accessed by Moda Health minus a percentage discount. Reimbursement for medications dispensed by all other providers will be subject to the Plan's benefit provisions and paid based on the lesser of either contracted rates, AWP or billed charges.

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 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 those services and supplies that are required for diagnosis or treatment of a medical condition and are:

- a. Appropriate and consistent with the symptoms or diagnosis of a member's condition
- b. Established as the standard treatment by the medical community in the service area in which they are received
- c. Not primarily for the convenience of a member or a provider
- d. The least costly of the alternative supplies or levels of service that can be safely provided to a member. For example, care rendered in a hospital inpatient setting is not medically necessary if it could have been provided in a less expensive setting, such as a skilled nursing facility or by a nurse in the member's home, without harm to the member

Medically necessary care does not include custodial care.

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. More information regarding medical necessity can be found in the General Exclusions (Section 7).

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 illness, as defined in the policy.

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

marriage and family therapist, or a clinician providing services under the auspices of a program licensed, approved, established, maintained, contracted with or operated by the Oregon Office of Mental Health & Addiction Services.

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

Moda Health refers to Moda Health Plan, Inc.

Moda Health Behavioral Health provides specialty services for managing mental health and chemical dependency benefits to help members access care in the right place and contain costs.

Network means a group of providers who contract to provide healthcare to members. 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 2.2).

Orthotic device means a rigid or semi-rigid device supporting a weak or deformed leg, foot, arm, hand, back or neck, or restricting or eliminating motion in a diseased or injured leg, foot, arm, hand, back or neck.

Out-of-network refers to providers that have not contracted under Moda Health to provide benefits to members.

Outpatient Surgery means surgery that does not require an inpatient admission or overnight stay.

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 may result in denial of benefits or a penalty (see section 3.1).

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. Examples of professional providers include:

- a. Acupuncturist
- b. Audiologist
- c. Autism service provider as defined above
- d. Chiropractor
- e. Community assessment center as defined in accordance to Oregon Revised Statute 418.782

- f. Dentist (doctor of medical dentistry or doctor of dental surgery), but only for treatment of accidental injury to natural teeth, or for surgery that does not involve repair, removal or replacement of teeth, gums, or supporting tissue
- g. Hearing aid specialist
- h. Mental health provider as defined above
- i. Naturopath
- j. Nurse (nurse practitioner including a certified nurse midwife and a registered nurse or licensed practical nurse providing services upon the written referral of a physician and for which nurses customarily bill patients)
- k. Optometrist
- l. Physician (doctor of medicine or osteopathy)
- m. Physician assistant
- n. Podiatrist
- o. Registered nurse first assistant
- p. Physical, occupational or speech therapist, but only for rehabilitative or habilitative services provided upon the written referral of a physician
- q. Tobacco cessation program following the United States Public Health guidelines for tobacco use cessation

Provider means an entity, including a facility, a medical supplier, a program or a professional provider, that is state licensed 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 illness or chemical dependency. Residential program does not include any program that provides less than 4 hours per day of direct treatment services.

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 the Marketplace 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.

SECTION 6. BENEFIT DESCRIPTION

The Plan covers services and supplies listed when medically necessary for diagnosis and/or treatment of a medical condition. 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 2.2).

Many services require prior authorization. A complete list is available on myModa or by contacting Customer Service. Failure to obtain required prior authorization may result in denial of benefits or a penalty (see section 3.1).

6.1 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.

6.2 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.

6.3 EMERGENCY CARE

Members are covered for treatment of emergency medical conditions worldwide. 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. All emergency services will be reimbursed at the in-network benefit level. However out-of-network providers may bill members for charges in excess of the maximum plan allowance.

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.

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. Preventive services
- b. Diagnostic work-ups for chronic conditions
- c. Elective surgery and/or hospitalization

6.4 HOSPITAL & RESIDENTIAL FACILITY CARE

A hospital is a facility that is licensed as an acute care hospital and that provides inpatient surgical and medical care to members who are acutely ill. Its services must be under the supervision of a staff of licensed physicians and must include 24-hour-a-day nursing service by registered nurses. Facilities that are primarily rest, old age or convalescent homes are not considered hospitals.

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.

Hospitalization must be directed by a physician and must be medically necessary.

All inpatient and residential stays require prior authorization (see section 3.1). Failure to obtain authorization will result in denial of benefits or a penalty.

6.4.1 Emergency Room Care

The Plan covers medically necessary emergency room care. See section 6.3 for more information.

6.4.2 Pre-admission Testing

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

6.4.3 Hospital Benefits

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

- a. **Hospital room.** The actual daily charge
- b. **Isolation care.** When Moda Health agrees it is necessary to protect other patients from contagion or to protect a member from contracting the illness of another person
- 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 necessary for treatment and ordinarily furnished by a hospital
- f. **Routine nursery care.** Including 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.

6.4.4 Inpatient Rehabilitative and Habilitative Care

Covered rehabilitative and habilitative care expenses are subject to an annual limit for inpatient services delivered in a hospital or other inpatient facility that specializes in such care. Additional days may be available for treatment required for neurological conditions (e.g., stroke, spinal cord or head injury, pediatric neurodevelopmental problems), subject to medical necessity and prior authorization. Medically necessary services for mental health and chemical dependency are not subject to these limits.

In order 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.

6.4.5 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 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 illness

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

6.4.6 Residential Mental Health and Chemical Dependency Treatment Programs

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

6.4.7 Chemical Dependency Detoxification Program

All-inclusive daily charge for room and treatment services by a treatment program that meets the definitions in the Plan are covered.

6.5 AMBULATORY SERVICES

Many ambulatory services require prior authorization (see section 3.1.2).

6.5.1 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.

6.5.2 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). However, 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. 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.

6.5.3 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. See section 6.9.6 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. IV bolus/push medications
- i. blood product administration

In addition, covered expenses include only the following medically necessary services and supplies:

- 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

6.5.4 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.

6.5.5 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

Members with end-stage renal disease (ESRD) are encouraged to enroll in Medicare Part B.

6.5.6 Imaging Procedures

The Plan covers all standard imaging procedures related to treatment of a medical condition. The following advanced imaging services require prior authorization (see section 3.1):

- a. Magnetic resonance imaging (MRI) or magnetic resonance angiography (MRA)
- b. Computerized axial tomography (CT or CAT) or computed tomography angiogram (CTA)
- c. Positron emission tomography (PET)
- d. Single photon emission computed tomography (SPECT)
- e. Echocardiography
- f. Nuclear cardiology studies

6.5.7 Outpatient Chemical Dependency Services

Services for assessment and treatment of chemical dependency in an outpatient treatment program are covered. Behavioral Health Customer Service can help members locate in-network providers and understand the chemical dependency benefits.

6.5.8 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. Moda Health is not liable for any adverse effects 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. Required solely for the prevention, diagnosis or treatment of complications arising from the provision of the drug, device or service being tested in the clinical trial
- d. Provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the member
- e. Customarily provided by a clinical trial sponsor free of charge to any person participating in the clinical trial

6.6 PROFESSIONAL PROVIDER SERVICES

6.6.1 Preventive Healthcare

As required under the Affordable Care Act, certain services will be covered at no cost to the member when performed by an in-network provider (see section 2.2 for benefit level when services are provided out-of-network):

- a. Evidence-based services rated A or B by the United States Preventive Services Taskforce (www.uspreventiveservicestaskforce.org/uspstf/uspstabrecs.htm)
- 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. 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. Periodic 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

An exam to rule out a diagnosis of illness based on family history is eligible for benefits as a periodic health exam based on the above schedule.

Routine diagnostic x-ray and lab work related to a periodic health exam are also covered and are subject 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 routine flexible sigmoidoscopy and pre-surgical exam or consultation every 5 years
 - ii. One routine 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

Colorectal cancer screening is covered at the medical benefit level if it is not performed for preventive purposes (e.g., screening is for diagnostic reasons or to check symptoms). For members who are at high risk for colorectal cancer with a family medical history of colorectal cancer, a prior occurrence of cancer or precursor neoplastic polyps, a prior occurrence of a chronic digestive disease condition such as inflammatory bowel disease, Crohn's disease or ulcerative colitis, or other predisposing factors, 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 preventive screening age and frequency limits.

6.6.2 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.

6.6.3 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.

6.6.4 Diabetes Self Management Programs

The Plan covers diabetes self management programs associated with 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. Upon a material change of condition, medication or treatment, the Plan will also cover up to 3 hours per year of assessment and training if:

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

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.

6.6.5 Nutritional Counseling

Dietary or nutritional counseling is covered for certain conditions. Benefits are provided under the diabetes self management benefit or for management of inborn errors of metabolism (excluding obesity). Nutritional counseling for anorexia nervosa or bulimia nervosa requires authorization after the first 5 visits. Preventive nutritional counseling that may be required under the Affordable Care Act is covered under the preventive care benefit.

6.6.6 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 home self-care, or through oral use of a prescription drug, administrative services for therapeutic injections are not covered. (Additional information in section 6.8.1 and 6.9.6). Vitamin and mineral injections are not covered unless medically necessary for treatment of a specific medical condition.

6.6.7 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

6.6.8 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.

6.6.9 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 same terms and conditions, including the prior authorization and cost sharing provisions, otherwise applicable under the Plan.

6.6.10 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. Reconstructive procedures that are partially cosmetic in nature may be covered if the procedure is medically necessary. Coverage is available for surgical repair of congenital deformities if prior authorized and medically necessary. All reconstructive procedures must be medically necessary and prior authorized or benefits will not be paid.

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.

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 6.6.9.

6.6.11 Cochlear Implants

Cochlear implants are covered when medically necessary and prior authorized.

6.6.12 Inborn Errors of Metabolism

The Plan covers treatment of inborn errors of metabolism that involve amino acid, carbohydrate and fat metabolism and 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.

6.6.13 Special Dental Care

Dental services 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 medically necessary and is provided by a physician or dentist while the member is covered by this policy

The Plan only covers treatment within 12 months of the date of injury. Covered treatment is limited to that which will restore teeth to a functional state. Implants and implant related services are not covered. Exceptions to the timelines may be made when medically necessary.

6.6.14 Facility Charges for Dental Procedures

General anesthesia services and related facility charges are covered in conjunction with 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.

6.6.15 Maxillofacial Prosthetic Services

The Plan covers maxillofacial prosthetic services considered 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 when such restoration and management are performed to control or eliminate infection or pain, or to restore facial configuration or functions such as speech, swallowing or chewing but not including cosmetic procedures to improve on the normal range of conditions.

6.6.16 Alternative Care

Alternative care is spinal manipulation, acupuncture services and naturopathic substances. 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.

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

There is an annual maximum for alternative care services. Reimbursement for other services and visit limits, 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, but a maximum of one copayment will apply per visit for alternative care and associated services by the same provider. Office visits by chiropractors and acupuncturists are considered specialist office visits unless they are credentialed as primary care providers.

6.6.18 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.

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

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, social counseling, 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

6.6.19 Mental Health

The Plan covers medically necessary outpatient services, other than diagnostic testing, by a mental health provider as defined in Section 5. Behavioral Health Customer Service can help members locate in-network providers and understand the mental health benefits. See section 6.5.4 for coverage of diagnostic services.

6.6.20 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).

6.6.21 Tobacco Cessation

The Plan covers expenses incurred when a member age 10 or older participates in a tobacco cessation program. Covered expenses include counseling, office visits, medical supplies, and drugs 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.

6.6.22 Telemedical Health Services

Covered medical services, when generally accepted healthcare practices and standards determine they can be safely and effectively provided using synchronous 2-way video conferencing, are covered when provided by an in-network provider using such conferencing as long as the application and technology used 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 telemedical services are 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.

6.6.23 Child Abuse Medical Assessment

Child abuse medical assessment provided by a community assessment center as defined in accordance to Oregon Revised Statute 418.782 is covered. Child abuse medical assessment includes a forensic interview and mental health treatment.

6.7 OTHER SERVICES

6.7.1 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.

6.7.2 Hospice Care

a. Definitions

Approved hospice means a private or public hospice agency or organization approved by Medicare or accredited by the Oregon Hospice Association (or a similar agency if services are provided outside of Oregon).

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

Respite care means care for a period of time to relieve persons residing with and caring for a member in hospice from their duties. Providing care to allow a caregiver to return to work does not qualify as respite care.

The Plan covers respite care provided to a member who requires continuous assistance when arranged by the attending professional provider and prior authorized. Benefits are provided for a limited number of days of covered hospice 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 approval is given by Moda Health in advance.

e. Exclusions

In addition to exclusions listed in Section 7, 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

6.7.3 Maternity Care

Pregnancy care, childbirth and related conditions, including voluntary 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 7. 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.

6.7.4 Breastfeeding Support

Comprehensive lactation support and counseling is covered during pregnancy and/or the postpartum 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.

6.7.5 Transplants

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

a. Definitions

Exclusive transplant network facility means a healthcare facility with which Moda Health has contracted or arranged to provide facility transplant services.

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. Covered Benefits Benefits for transplants are limited as follows:

- i. Transplant procedures must be performed at an exclusive transplant network facility. If an exclusive transplant facility cannot provide the necessary type of transplant, Moda Health will prior authorize services at an alternative transplant facility.
- ii. 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. If the donor is enrolled in this policy and the recipient is not enrolled, the Plan will not pay any benefits toward donor costs. Expenses incurred by a donor not enrolled in the policy that result from complications and unforeseen effects of the donation are not covered. "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.
- 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 plan 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 Medication benefit (section 6.9).
- 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.

- c. **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.

6.7.6 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.

6.7.7 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 section 6.7.2.

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. Home healthcare requires prior authorization.

6.7.8 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 if they are 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.

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 or one contact lens or eyeglasses is covered for each eye operated on.

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 (section 6.7.9), eyeglasses and contact lenses (above and section 6.7.10).

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

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 durable medical equipment include a wheelchair, a hospital-type bed and oxygen.

The Plan covers the rental charge (not to exceed the purchase price) for durable medical equipment. Upon request, members must authorize any supplier furnishing durable medical equipment 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 durable medical equipment 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 7, 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. Wigs and toupees
- c. Those used for education or environmental control (additional information regarding Supportive Environmental materials can be found in Section 7)
- d. Therapeutic devices, except for transcutaneous nerve stimulators
- e. Incontinence supplies

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

6.7.9 Hearing Aids

The Plan covers one hearing aid per hearing impaired ear for members under age 26. Members must be examined by a physician before obtaining a hearing aid that is prescribed, fitted and dispensed by a licensed audiologist or hearing aid specialist.

Covered benefits include the following every 48 months:

- a. A hearing aid (monaural or binaural) prescribed as a result of the examination
- b. Ear molds
- c. Hearing aid instruments
- d. Initial batteries, cords and other necessary supplementary equipment
- e. A warranty
- f. Repairs, servicing or alteration of the hearing aid equipment

6.7.10 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.

6.7.11 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.

6.8 MEDICATIONS

6.8.1 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 a supply. If the pharmaceutical is available in an oral dosage form, the Plan will not cover it in the form of an injectable medication unless it is medically necessary that the member use the injectable form. In addition, infusion and in-office injectables may require prior authorization by Moda Health or be subject to specific benefit limitations (more information is available on the Moda Health website). Self-administered medications are not covered under this benefit (see section 6.9.6). See section 6.9 for pharmacy benefits.

6.8.2 Anticancer Medication

Prescribed anticancer medications, including oral, intravenous (IV) or injected medications, are covered. Anticancer medications require prior authorization and may be subject to specific benefit limitations. Self-administered medications require delivery by an exclusive specialty

pharmacy (see section 6.9.6). 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. See also sections 6.9 and 6.5.3.

6.9 PHARMACY PRESCRIPTION MEDICATION BENEFIT

6.9.1 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 will 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 prescription medication 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 physicians and pharmacists 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 clinically effective at a favorable cost when compared to other medications in the same therapeutic class and/or category. Generic medications that have been identified as having no more favorable outcomes, from a clinical perspective, than other more cost effective generic medications may be included in this tier.

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 and new FDA approved medications are subject to review and may be subject to additional coverage parameters, requirements or limits 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 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 hospital, physician office or infusion center) and that does not usually require administration by a licensed medical provider.

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 must be prior authorized.

Value Tier Medications. Value medications include commonly prescribed products used to treat chronic medical conditions and preserve health. A list of value tier medications is available on myModa.

6.9.2 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

6.9.3 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, and glucose tablets when accompanied by a valid prescription
- d. Select prescribed preventive medications required under the Affordable Care Act
- e. Medications for treating tobacco dependence, including prescribed OTC nicotine patches, gum or lozenges from an in-network retail pharmacy available with no cost sharing as required under the Affordable Care Act

- f. Legend contraceptive medications and devices for birth control (section 6.6.2) 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.
- g. Select immunizations (section 6.6.1) and related administration fees are covered with no cost sharing at in-network retail pharmacies (e.g. influenza, pneumonia and shingles vaccines)

Certain prescription medications and/or quantities of prescription medications may require prior authorization (see section 3.1.3). 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 Customer Service.

6.9.4 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.

6.9.5 Specialty Services and Pharmacy

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. Specialty medications are often used to treat complex chronic health conditions. Because specialty treatments often require special handling techniques, careful administration and a unique ordering process, the Plan provides enhanced member services for these medications. Information about the clinical services and a list of eligible specialty medications is available on myModa or by contacting Customer Service. If a member does not purchase these medications at the exclusive specialty pharmacy, the expense will not be covered.

Specialty medications must be prior authorized. Some specialty prescriptions may have shorter day supply coverage limits. More information is available on myModa or by contacting Customer Service. 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.

6.9.6 Self Administered Medication

All self-administered medications are subject to the pharmacy prescription medication requirements of section 6.10. Self-administered specialty medications are subject to the same requirements as other specialty medications (section 6.9.5). For some specialty medications, members may be required to enroll in programs to ensure patient safety, proper drug use and/or reduce the cost of the medication.

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

6.9.7 Step Therapy

Step therapy requires members to try selected medications before proceeding to alternative treatments. Brand medications are available as shown in section 2.2 once members have tried and failed first line therapies.

6.9.8 Limitations

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

- a. In addition to those medications included in the current prior authorization list on myModa, prior authorization is required for
 - i. Retail prescriptions with a net cost over \$1,500 for a 30-day supply
 - ii. Mail order prescriptions with a net cost over \$4,500
 - iii. Specialty prescriptions with a net cost over \$8,000
 - iv. Compounded medications with a net cost over \$150 for a 30-day supply
- b. 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
- c. 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.
- d. Select 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. This includes a 12-month supply of contraceptives when permitted by law.
- 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. When allowed, is limited to once every 6 months

6.9.9 Exclusions

In addition to the exclusions listed in Section 7, 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 6.9.3 and for other devices in section 6.7.8
- 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 in whole or in part while the member is a patient in a hospital, sanitarium, 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 Resources Commission
- m. **Over the Counter (OTC) Medications** and prescription medications for which there is an OTC equivalent or alternative
- n. **Repackaged Medications**
- o. **Replacement Medications and/or Supplies**
- p. **Weight Loss Medications**

SECTION 7. 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. In addition, 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

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 following a mastectomy (section 6.6.9) and complications of reconstructive surgeries if medically necessary and not specifically excluded.

Court Ordered Sex Offender Treatment

Custodial Care

Routine care and hospitalization for assistance with activities of daily living, including but not limited to bathing, dressing, feeding and administration of medications. Custodial care also includes care that is primarily for the purpose of separating a member from others, or for preventing a member from harming himself or herself.

Dental Examinations and Treatment; Orthodontia

Except as specifically provided for in sections 6.6.13, and 6.6.15, or if medically necessary to restore function due to craniofacial anomaly

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

Faith Healing**Family Planning**

Surgery to reverse voluntary 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 6.7.9

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 mental illness or as specifically provided for in section 6.6.23

Missed Appointments**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 6.6.5

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 6.7.8

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. Paring or cutting of benign hyperkeratotic lesion (e.g., corn or callus)
- b. Trimming of dystrophic and non-dystrophic nails
- c. Debridement of nails by any method

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 6.9 and 6.8.2)

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

The Plan does not cover 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

Surgery to Alter Refractive Character of the Eye

Any procedure that alters the refractive character of the eye, the purpose of which is to cure or reduce myopia, hyperopia or astigmatism. Includes reversals or revisions of any such procedures and any complications of these procedures.

Taxes

Telemedical Health Services

Including telephone visits or consultations and telephone psychotherapy, except as specifically provided for in section 6.6.22

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, 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 10.4.2)

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 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. For example, coverage is not allowed for an inpatient hospital stay when an appropriate level of treatment could be delivered in an outpatient setting such as an ambulatory surgery facility

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

Vitamins and Minerals

Unless medically necessary for treatment of a specific medical condition and prescribed and dispensed by a licensed professional provider. Applies whether the vitamin or mineral is oral, injectable or transdermal.

Wigs, Toupees, Hair Transplants**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 under any workers' compensation provision. 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 8. ELIGIBILITY & ENROLLMENT

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

To be a subscriber, a person must be a qualified individual eligible to enroll through the Marketplace, who lives in the state of Oregon and intends to live in the state permanently or indefinitely. Coverage is not available to a person who is enrolled on a Medicare plan, who is not in the United States legally or who resides in Oregon for the primary purpose of obtaining health coverage. Subscribers may enroll their eligible dependents under the same policy by including them on the application with the Marketplace.

Eligibility and enrollment, including premium tax credit and allocations for American Indian and Alaskan Native eligibility status, are administered by the Marketplace. Contact the Marketplace for information.

A new dependent may cause a premium increase. The subscriber must notify the Marketplace if family members are added or dropped from coverage, even if it does not affect premiums. Moda Health must be notified whenever there is a change of address.

To remain eligible for coverage, a person must be a resident in the state of Oregon and reside in the service area for at least 6 months out of the calendar year. Resident means a person who lives in the state of Oregon, and intends to live in the state permanently or indefinitely.

A subscriber's child who has sustained a disability rendering him/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.

8.1 ENROLLING NEW DEPENDENTS

A subscriber may obtain coverage for newly acquired or newly eligible dependents by submitting an application (along with placement or adoption paperwork, if applicable) within 60 days of their eligibility.

8.2 OPEN ENROLLMENT PERIODS

Persons can apply for coverage during the open enrollment period. For 2016, open enrollment is from November 1, 2015 to January 31, 2016. These dates may be different for future years.

American Indians and Alaskan Natives, Oregon Health Plan participants, and Healthy Kids participants can apply for coverage in monthly enrollment periods.

8.3 SPECIAL ENROLLMENT PERIODS

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

- a. Loss of minimum essential coverage through an employer but not as a result of 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, or a court order
- d. Becoming a citizen, national or lawfully present individual
- 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), or of a non-Marketplace entity providing enrollment assistance or conducting enrollment activities
- f. Having adequate evidence that there is a violation of a material provision made by the Qualified Health Plan in which he or she is enrolled
- g. Becoming eligible for advanced payments of the premium tax credit
- h. Having a change in eligibility for cost sharing reductions
- i. Moving permanently to a new location with access to new qualified health plans (QHPs)
- j. Having other exceptional circumstances in accordance with guidelines issued by HHS and accepted by the Marketplace

8.4 WHEN COVERAGE BEGINS

Coverage begins for new applicants and their eligible dependents on the 1st day of the following month if an application is received from the 1st to the 15th of a month, or the 1st of the second month if an application is received from the 16th to the last day of the month.

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 and persons who qualified due to the loss of minimum essential coverage, coverage begins on the 1st of the month following plan selection.

The required premium or any applicable premium credit must be processed by the Marketplace for coverage to become effective.

8.5 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.

8.6 PREMIUMS

The current premium amount is shown on the notice from the Marketplace. Members may contact the Marketplace regarding premium tax credits.

Premium payments are due monthly for continued coverage. Payments can be made by check, cashier's check or money order 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 or a credit or debit card.

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

8.6.1 When Payments are Due

All premium payments are due in advance. Moda Health will allow a 20-day grace period after the premium due date. Members who are eligible for tax credits and taking any portion as a prepaid subsidy will be allowed a 3 month grace period. 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 unless otherwise required by law.

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

8.6.2 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 the subscriber 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.

8.6.3 Segregation of Premium for Abortion Services

The first full dollar of any member-paid monthly premium is allocated to abortion services for which public funding is prohibited. Federal regulations require that the premium for these services be at least \$1.00 per member per month, regardless of age or gender. Although this charge is built into the premium and not billed separately, Moda Health allocates the funds as required by law.

8.7 WHEN COVERAGE ENDS

The circumstances in which a member's coverage will end are described below. Coverage will end on the last day of the month through which premiums are paid. When the subscriber's coverage ends, coverage for all enrolled dependents also ends.

- a. The subscriber is no longer eligible for coverage through the Marketplace
- b. The subscriber moves outside the Plan's service area
- c. Loss of dependent eligibility
- d. Non-payment of premium
- e. Rescission for fraud or intentional material misrepresentation, which 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
- f. Termination of the health benefit plan option
- g. Moda Health's decertification to offer plans through the Marketplace
- h. Subscriber terminates his or her coverage after 14-day advanced notice or changes health benefit plan during an open enrollment or special enrollment period

8.8 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, which 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.

SECTION 9. CLAIMS ADMINISTRATION & PAYMENT

10.1 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.

A provider may collect any applicable copayments at the time of service. An in-network provider cannot require advance payment of deductible and coinsurance amounts, but must bill Moda Health first.

10.1.1 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.

The same procedure should be followed with bills for hospital or professional provider care received outside the United States.

10.1.2 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.

10.1.3 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 10.1.4. 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.

10.1.4 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.

10.1.5 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 10.1.

10.1.6 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.

10.2 COMPLAINTS, APPEALS AND EXTERNAL REVIEW

10.2.1 Definitions

For purposes of section 10.2, 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 (this notice will come from the Marketplace) 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 or the Marketplace 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 the Marketplace or an agent acting on behalf of Moda Health or the Marketplace, 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.

10.2.2 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).

10.2.3 Appeals

Appeals regarding eligibility, including premium tax credit and allocations or American Indian and Alaskan Native eligibility status, should be sent to the Marketplace.

Appeals of other adverse benefit determinations are administered by Moda Health. 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.

10.2.4 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 Insurance Division.

- 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 10.3); 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 10.2.3. 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.

10.2.5 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 health care service
- b. Claims payment, handling or reimbursement for health care 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.

10.2.6 Additional Member Rights

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

Phone: 503-947-7984 or toll-free 888-877-4894
Mail: PO Box 14480, Salem, Oregon 97309-0405
Internet: www.oregon.gov/DCBS/insurance/gethelp/Pages/fileacomplaint.aspx
email: cp.ins@state.or.us

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

10.3 CONTINUITY OF CARE

10.3.1 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.

10.3.2 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

10.3.3 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.

10.4 BENEFITS AVAILABLE FROM OTHER SOURCES

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

10.4.1 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 10.

10.4.2 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 10.4.2. 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.

10.4.2.1 Definitions:

For purposes of section 10.4.2, 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.

10.4.2.2 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.

10.4.2.3 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 applicable state law.

10.4.2.5 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. Moda Health 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 10.4.2, 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 Moda Health 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 Moda Health, 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 10.4.2.
- 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 10.4.2.
- f. Section 10.4.2 applies to any member for whom advance payment of benefits is made by Moda Health 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, Moda Health 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.

10.5 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 or would have been paid under Medicare Part A or 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.

Members with end-stage renal disease (ESRD) should enroll in Medicare as soon as they are eligible to do so.

SECTION 10. COORDINATION OF BENEFITS

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

11.1 DEFINITIONS

For purposes of Section 11, 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 trustee plan, a union welfare plan, an employer organization plan or an employee benefits plan
- d. Medical care components of group or individual 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 or individual 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.

11.2 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.

11.3 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.

11.4 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.

11.5 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 10.1.4).

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 11. MISCELLANEOUS PROVISIONS

12.1 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 12.10).

12.2 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.

12.3 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 503-243-4492.

12.4 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.

12.5 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.

12.6 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.

12.7 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.

12.8 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 or damages connected with injuries a member suffers while receiving medical services or supplies.

12.9 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.

12.10 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 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 743.766
- d. 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
- e. 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
- f. 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.

12.11 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.

12.12 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 compliance with federal mental health parity requirements and coverage of essential health benefits as defined by the Affordable Care Act, except that the policy does not provide the required pediatric dental coverage. Members who have purchased this policy outside of the Marketplace must have obtained separate pediatric dental coverage through a Marketplace certified pediatric dental plan. This applies whether the member is an adult or a child. A list of Marketplace certified pediatric dental plans can be found at the Marketplace website. Delta Dental Plan of Oregon, part of the Moda Health organization, offers plans that include pediatric dental coverage. Visit the Moda Health website to review the available options.

Members who have not met the requirement to obtain pediatric dental coverage should contact Moda Health for assistance.

12.13 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.

12.14 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.

12.15 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 10.1). All internal levels of appeal under the Plan must be exhausted before filing a legal action in court.

12.16 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 12. 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.

13.1 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. 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.
- h. Obtain free language assistance services, including verbal interpretation services, when communicating with Moda Health
- i. 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.
- j. 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. Treat all providers and their staff with courtesy and respect
- c. Provide all the information needed for their provider to provide good healthcare
- d. Participate in making decisions about their medical care and forming a treatment plan
- e. Follow instructions for care they have agreed to with their provider
- f. Use urgent and emergency services appropriately
- g. Present their medical identification card when seeking medical care
- h. Notify providers of any other insurance policies that may provide coverage
- i. Reimburse Moda Health from any third party payments they may receive

- j. 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
- k. Seek regular health checkups and preventive services
- l. 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.

13.2 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.

13.3 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.

13.4 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 10.2.

A member may also contact the Oregon Insurance Division

Phone: 503-947-7984 or toll-free 888-877-4894
Mail: PO Box 14480, Salem, Oregon 97309-0405
Internet: www.oregon.gov/DCBS/insurance/gethelp/Pages/fileacomplaint.aspx
email: cp.ins@state.or.us

13.5 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. 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.

13.6 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

13.7 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.

13.8 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.

13.9 What additional information is available upon request?

The following documents are available 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

13.10 What information about Moda Health is available from the Oregon Insurance Division?

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

- 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 Insurance Division
PO Box 14480, Salem, Oregon 97309-0405
503-947-7984 or toll-free 888-877-4894
www.oregon.gov/DCBS/insurance/gethelp/Pages/fileacomplaint.aspx
cp.ins@state.or.us



For help call us directly at 888-393-2940

(En Español: 888-786-7461)

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