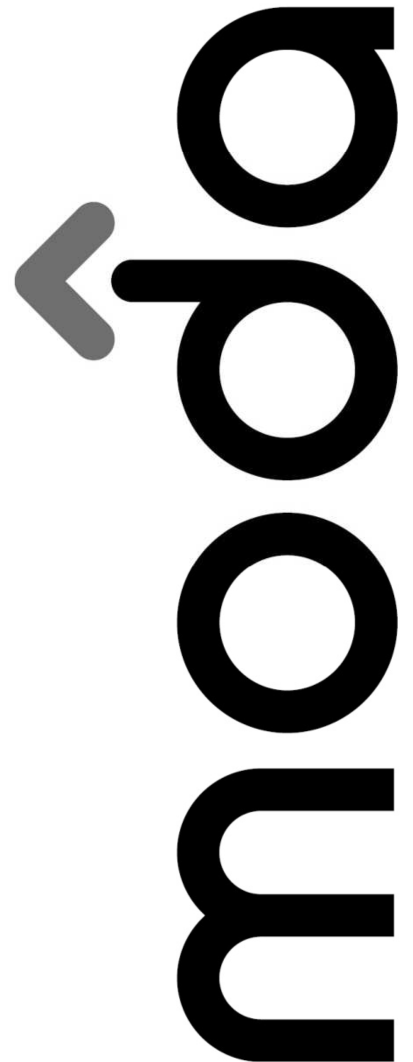
Group Medical Plan



Summit Full-Time +100
Effective Date: January 1, 2016
Group Number: 10002802

Health plans in Oregon by Moda Health Plan, Inc.

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SECTION 1. WELCOME

Moda Health is pleased to have been chosen by the Group for its Summit plan. This handbook is designed to provide members with important information about the Plan's benefits, limitations and procedures.

Members may direct their 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/pebb. 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 handbook may be changed or replaced at any time, by the Group or Moda Health, without the consent of any member. The most current handbook is available on myModa, accessed through the Moda Health website. All plan provisions are governed by the Group's policy with Moda Health. This handbook may not contain every plan provision.

1.1 MEMBER RESOURCES

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

Medical Customer Service Department
Toll-free 844-776-1593
En Español 503-265-2961; Llamado gratis 888-786-7461

Pharmacy Customer Service Department
Toll-free 844-776-1594

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

Telecommunications Relay Service for the hearing impaired
711

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

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

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 of the Plan are contained in the sections that follow. An explanation of important terms is found in Section 6.

Section 4.1 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.

2.1 Network Information

In-network benefits apply to services delivered by medical home providers or providers with a referral; out-of-network benefits apply to services delivered by non-medical home providers or providers without a referral . By using a medical home provider, members will receive quality healthcare and will have a higher level of benefits. See Section 3 for more information on medical homes. Members may find a medical home provider by using "Find Care" on myModa or by contacting Customer Service for assistance. Member ID cards will identify the applicable network(s).

2.1.1 Primary Network; Primary Service Area

All members will have access to a primary network, which provides services in their primary service area. Subscribers must reside or work within the primary service area. Subscribers who move outside of a network service area must contact Customer Service to find out if another network is available to ensure continued access to in-network providers.

Networks

Medical: Summit Network including Baker, Gilliam, Grant, Harney, Lake, Malheur, Morrow, Sherman, Umatilla, Union, Wallowa and Wheeler counties.

Pharmacy: Northwest Prescription Drug Consortium

2.1.2 Coverage Outside the Service Area for Children

Enrolled children residing 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 providers 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 whose assigned network provides nationwide access.

Travel Network
Healthy Directions

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

2.2 SCHEDULE OF BENEFITS

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

	In-Network Benefits	**Out-of-Network Benefits**
Annual Medical Deductible per Member	**$350**	**$600**
Maximum Annual Medical Family Aggregate Deductible	**$1,050**	**$1,800**
Annual Medical Out-of-Pocket Maximum per Member	**$1,500**	**$2,500**
Annual Medical Out-of-Pocket Maximum per Family	**$4,500**	**$7,500**
Maximum Annual Cost Sharing per Member (Medical & pharmacy)	**$6,350**	**N/A**
Maximum Annual Cost Sharing per Family (Medical & pharmacy)	**$12,700**	**N/A**

Services	**Cost Sharing** (Deductible applies unless noted differently)		**Section in Handbook & Details**
	In-network	**Out-of-network**	
Emergency Care			
Emergency Room Facility	$100 per visit*	$100 per visit*	Section 7.4.1 In-network deductible and out-of-pocket maximum apply to mental health and chemical dependency services. Copay waived if covered hospitalization immediately follows emergency room use. All services subject to inpatient benefits. Other ancillary services subject to standard copay per service

Services	Cost Sharing (Deductible applies unless noted differently)		Section in Handbook & Details
	In-network	Out-of-network	
Hospital Care and Residential Facility Care			
Inpatient Acute Care	$50 per day/$250 per admission	30%	Section 7.4.3
Observation Care	$50 per day/$250 per admission	30%	Section 7.4.3
Routine Newborn Nursery Care	$50 per day/$250 per admission	30%	Section 7.4.3
Bariatric Surgery Facility	$50 per day/$250 per admission	Not covered	Section 7.4.3
Inpatient Rehabilitation	$50 per day/$250 per admission	30%	Section 7.4.4 30 days per year. May be eligible for up to 60 days for head or spinal cord injury, or for treatment of a stroke.
Skilled Nursing Facility Care	$50 per day/$250 per admission	30%	Section 7.4.5 180 days per year
Residential Mental Health Treatment Program	$50 per day/$250 per admission	30%	Section 7.4.6
Residential Chemical Dependency Treatment Program	No cost sharing	30%	Section 7.4.6
Chemical Dependency Detoxification	No cost sharing	30%	Section 7.4.7
Ambulatory Services			
Outpatient Rehabilitation	$5 per visit	30%	Section 7.5.2 60 sessions per year and maximum does not apply to mental health and chemical dependency services.
Cardiac Rehabilitation	$5 per visit	30%	Section 7.5.2
Infusion Therapy			Section 7.5.3
Home or Outpatient	$5 per service	30%	
Diagnostic X-ray and Lab	No cost sharing	30%	Section 7.5.4
Allergy Shots, Serums	$5 per service	30%	Section 7.5.4
Therapeutic X-ray	$5 per service	30%	Section 7.5.5
Kidney Dialysis	$5 per service	30%	Section 7.5.5

Services	Cost Sharing (Deductible applies unless noted differently)		Section in Handbook & Details
	In-network	**Out-of-network**	
Imaging Procedures	$100 per service*	$100* per service, then 30%	Section 7.5.6 Copay does not apply to services related to cancer diagnosis and treatment
Outpatient Chemical Dependency Services	No cost sharing	30%	Section 7.5.7
Chemical Dependency Day Treatment	No cost sharing	30%	Section 7.4.6
Mental Health Day Treatment	$5 per visit	30%	Section 7.4.6
Outpatient Services (Facility Charges)	$5 per service	30%	Section 7.5.1
Professional Services			
Preventive Healthcare, including those required under the Affordable Care Act.			Section 7.6.1
Periodic Health Exams (by primary care provider only)	No cost sharing	30%	7 exams from age 1 to 4 One per year, age 5+
Immunizations	No cost sharing	30%	
Newborn Hearing Screening	No cost sharing	30%	
Routine Vision Screening	No cost sharing	30%	Age 3 to 5
Women's Annual Exam & Pap Test	No cost sharing	30%	One per year
Routine Mammogram	No cost sharing	30%	One per year, age 40+
Routine Colonoscopy	No cost sharing	30%	One per 10 years, age 50+. Related charges included
Routine Diagnostic X-ray & Lab	No cost sharing	30%	
Prostate Rectal Exam	No cost sharing	30%	One per year, age 50+
Prostate Specific Antigen (PSA) Test	No cost sharing	30%	One per year, age 50+
Nutritional counseling	No cost sharing for first 2 visits, then $5 per visit	30%	4 visits per year except no visit limit if related to bariatric surgery and eating disorder

Services	Cost Sharing (Deductible applies unless noted differently)		Section in Handbook & Details
	In-network	**Out-of-network**	
Office Visits to Primary Care Providers	$5 per visit (First 4 visits deductible waived)	30%	Section 7.6.3
Urgent Care Office Visit	$25 per visit	$25 per visit	Section 7.6.3
Specialist Visits	$5 per visit	30%	Section 7.6.3
Office Visits to Naturopaths, Chiropractors and Acupuncturists	$5 per visit*	30%**	Section 7.6.3
Office Visits to Chronic Conditions	No cost sharing	30%	Section 7.6.3 Chronic conditions such as asthma, diabetes, heart conditions
E-Visits	No cost sharing	Not covered	Section 7.6.4
Inpatient Physician Hospital Visits (including surgery and anesthesia)	No cost sharing	30%	Section 7.6.3
Outpatient Diabetic Instruction	$5 per visit	30%	Section 7.6.6 Once, following diagnosis
Therapeutic Injections	$5 per service	30%	Section 7.6.7
Outpatient Surgery	$5 per procedure	30%	Section 7.6.8
Additional Cost Tier			Section 7.6.8 Does not include services related to cancer diagnosis or treatment for traumatic injury
Bunionectomy	$100 per service*	$100*, then 30%	
Hammertoe surgery	$100 per service*	$100*, then 30%	
Knee viscosupplementation	$100 per service*	$100*, then 30%	
Morton's neuroma	$100 per service*	$100*, then 30%	
Spinal injections for pain	$100 per service*	$100*, then 30%	
Upper gastrointestinal endoscopy	$100 per service*	$100*, then 30%	
Knee arthroscopy	$500 per service*	$500*, then 30%	
Knee, hip replacement	$500 per service*	$500*, then 30%	
Knee, hip resurfacing	$500 per service*	$500*, then 30%	
Shoulder arthroscopy	$500 per service*	$500*, then 30%	
Sinus surgery	$500 per service*	$500*, then 30%	
Spine procedures	$500 per service*	$500*, then 30%	
Bariatric surgery	$500 per service*	Not covered	
Special Dental Care	$5 per procedure	30%	Section 7.6.14
Temporomandibular Joint Syndrome	$5 per service	Not covered	Section 7.6.16 Related physical therapy visits up to 20 visits per year

Services	Cost Sharing (Deductible applies unless noted differently)		Section in Handbook & Details
	In-network	**Out-of-network**	
Outpatient Mental Health Services	$5 per visit	30%	Section 7.6.17
Tobacco Cessation Treatment			Section 7.6.19 Age 10+
Quit for Life – Consultation and Supplies	No cost sharing	N/A	
All other providers – Consultation	No cost sharing	Not covered	
All other providers – Supplies	No cost sharing	15%	
Spinal Manipulation and Acupuncture	$5/visit*	30%**	Section 7.6.20 $1,000 aggregate year maximum
Applied Behavior Analysis	$5/visit	30%	Section 7.6.21
Other Services			
Ambulance Transportation	$75 per trip	$75 per trip	Section 7.7.1
Hospice Care			Section 7.7.2
Home Care	No cost sharing	No cost sharing	
Inpatient Care	No cost sharing	No cost sharing	
Respite Care	No cost sharing	No cost sharing	
Maternity			Section 7.7.3
Facility Charges	$50 per day/$250 per admission	30%	
Prenatal Visits	No cost sharing	30%	
Professional Delivery and Postnatal	No cost sharing	30%	
Breastfeeding Support, Supplies and Counseling	No cost sharing	No cost sharing	Section 7.7.4
Infertility services	50%**	50%**	Section 7.7.7
Transplants			Section 7.7.5
(Exclusive transplant network facilities)			
Facility charges	$50 per day/$250 per admission	N/A	
Professional charges	$5 per visit	N/A	
Biofeedback	$5 per visit	30%	Section 7.7.8 10 visits
Home Healthcare	$5 per visit	30%	Section 7.7.9 180 visits per year
Outpatient Durable Medical Equipment	15%	30%	Section 7.7.10
Supplies and Appliances	15%	30%	Section 7.7.10

Services	Cost Sharing (Deductible applies unless noted differently)		Section in Handbook & Details
	In-network	**Out-of-network**	
Diabetic Supplies and Insulin	No cost sharing	No cost sharing	Section 7.7.10
Disposable Supplies (provided in a professional provider's office)	15%	30%	Section 7.7.10
Hearing Exams	$5 per visit*	30%**	Section 7.7.11 Once every year
Hearing Aids and Related Services	10%**	10%** (in-network deductible applies)	Section 7.7.11 Once every 48 months
Sleep Studies	$100 per procedure*	$100*, then 30%	
Medications			
Injectable Medications	$5 per visit	30%	Section 7.9
Self-administered Chemotherapy Medications			Section 7.9 30-day supply. Specialty medications must be from the exclusive pharmacy provider
Generic	$5 (deductible waived)	30%	
Brand	$5 (deductible waived)	30%	
Prescription Medications			Section 7.9 Deductibles $50 per member $150 per family Out-of-pocket maximums $1,000 per member $3,000 per family
Retail Pharmacy			Up to 30-day supply per prescription, and up to 90 day supply in the Choice 90 Program***
Value Tier	No cost sharing	No cost sharing	
Generic Tier	$10	$10	
Brand Tier	$30	$30	
Mail Order Pharmacy			90-day supply per prescription
Value Tier	No cost sharing	N/A	
Generic Tier	$25	N/A	

Services	Cost Sharing (Deductible applies unless noted differently)		Section in Handbook & Details
	In-network	Out-of-network	
Brand Tier	$75	N/A	
Specialty Pharmacy			Up to 30-day supply per prescription
Generic Tier	$100	N/A	
Brand Tier	$100	N/A	
Self-administered Chemotherapy Medications			Up to 30-day supply per prescription
Retail Pharmacy	$5	$5	
Specialty Pharmacy	$5	N/A	

* Copayment does not apply to the medical out-of-pocket maximums.
** Coinsurance does not apply to the medical out-of-pocket maximums.
*** The copay for a 90-day supply at a Choice 90 pharmacy would be 2.5 times the copay for the 30 day supply.

2.3 DEDUCTIBLES

The Plan has separate annual medical and pharmacy deductibles. The deductible amounts are shown in section 2.2 and are the amount of covered expenses that are paid by members before benefits are payable by the Plan. All in-network and out-of-network accumulate separately. Covered prescription drug expenses are subject to the pharmacy deductibles. 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.

Copayments, prescription drug out-of-pocket expenses, and disallowed charges do not apply toward the annual medical deductible.

Generic and brand drugs dispensed at retail, specialty and mail order pharmacies are subject to the pharmacy deductibles (as shown in section 2.2.), which is calculated separately from any other deductible that may apply to the Plan.

If medical covered expenses under this Plan incurred in the last 3 months of a calendar year are applied toward the deductible for that year, they will also be carried forward and applied toward the deductible but not the maximum cost sharing for the following year.

If the Plan replaces a group policy of the Group, any deductible amount satisfied under the prior policy during the year will be credited.

Deductibles are accumulated on a calendar year basis. If the Plan renews on a date other than January 1st, members may be liable for additional deductible after renewal through December 31st.

2.4 ANNUAL MAXIMUM OUT-OF-POCKET

After a per member or per family annual out-of-pocket maximum is met, the Plan will pay 100% of covered services for the remainder of the year, except for services that are not applicable to the out-of-pocket maximums and that do not qualify as essential health benefits. All out-of-pocket maximums accumulate separately and are not combined. If coverage is for more than one member, the per member maximum applies only until the total family out-of-pocket maximum is reached.

The Plan has separate out-of-pocket maximums for prescription medication expenses (as shown in section 2.2, which is calculated separately from any other out-of-pocket limit that may apply to the Plan. Expenses incurred due to brand substitution do not accrue to the out-of-pocket maximum. Once the out-of-pocket maximum is met, covered prescriptions will be reimbursed at 100%.

Out-of-pocket costs are accumulated on a calendar year basis. If the Plan renews on a date other than January 1st, members may be liable for additional out-of-pocket costs after renewal through December 31st.

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. Medical and Prescription deductibles
b. Cost sharing for office visits to naturopaths, chiropractors and acupuncturists
c. Cost sharing for emergency services
d. Cost sharing for imaging services
e. Cost sharing for infertility services
f. Cost sharing for hearing exams and hearing aids
g. Cost sharing for sleep studies
h. Cost sharing for spinal manipulation and acupuncture
i. Cost sharing for additional cost tier
j. Cost sharing for non-essential health benefits
k. Disallowed charges

2.5 MAXIMUM COST SHARE

The maximum cost share is the annual limit on cost sharing for essential health benefits as required under the Affordable Care Act (ACA). Maximum cost sharing includes in-network deductibles, copayments and coinsurance paid by a member for essential health benefits. After a per member or per family annual maximum cost sharing is met, the Plan will pay 100% of in-network covered essential health benefits for the remainder of the year.

The maximum cost share is different from the out-of-pocket maximums and can only be met by cost sharing for in-network covered expenses that qualify as essential health benefits. Cost sharing applied to the maximum cost sharing also applies to the in-network out-of-pocket maximums.

Essential health benefits include the following categories:

a. Ambulatory services
b. Emergency services

c. Hospitalization
d. Maternity and newborn care
e. Mental health and chemical dependency service
f. Prescription medications
g. Rehabilitative and habilitative services and devices
h. Laboratory tests;
i. Preventive and wellness services and chronic disease management
j. Pediatric services including oral and vision care, if any

The following out-of-pocket costs do not apply toward the maximum cost share:

a. Services in excess of any maximum
b. Spinal manipulation and acupuncture services
c. Fees in excess of maximum plan allowance
d. Other services that do not qualify as essential health benefits
e. Premiums and penalties
f. Disallowed charges

2.6 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, deductibles and copayments or coinsurance 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. MEDICAL HOMES

3.1 MEDICAL HOMES

The Plan provides the highest benefit level for services provided by medical home providers. At enrollment, members are required to select a primary care provider from the medical homes (section3.2).

Medical home providers will coordinate medical care for members and arrange for care from specialists and prior authorization. These providers have an on-call system to provide 24-hour service. Members who need to contact their medical home provider after normal office hours should call his or her regular office number.

If a member does not select and properly utilize the primary care services of a medical home provider, claims will be paid at the out-of-network benefit level. Members who did not select a medical home provider at the time of enrollment application will need to inform Moda Health of the selection prior to receiving treatment. If a claim is received by Moda Health prior to the member selecting a medical home provider, the claim(s) will be paid at the lower benefit level. Subsequent claims will be paid at the lower benefit level until a medical home provider is selected.

3.2 HOW TO SELECT A MEDICAL HOME PROVIDER:

At enrollment members are required to select a medical home provider. Each covered family member may choose the same or a different medical home, depending upon their needs and preference. Members may find a medical home provider online by using "FindCare" on myModa. Members should contact the medical home to verify they are accepting new patients if they are not currently established with that provider. Once a medical home has been selected, the member should communicate their selection to Moda Health in one of the following ways before receiving services.

a. Online: Once the subscriber has received their medical ID card, members can use their myModa account to indicate their selected medical home for each covered family member
b. Phone: Contact Customer Service
c. Mail, fax or email: Download and complete the Medical Home selection form located at www.modahealth.com/pebb

   Mail Moda Health
   Attn: PEBB Billing and Eligibility
   PO Box 40384
   Portland, OR 97240

In order to change the medical home selection, members will need to select their new medical home and communicate the change to Moda Health using the options provided above.

3.3 MEDICAL HOME PRIMARY CARE PROVIDERS

The medical home primary care provider (PCP) will be the first professional provider a member should contact for medical care. A medical home PCP is a professional provider who specializes in family practice, general practice, internal medicine or pediatrics. Enrolled children may choose a pediatrician and female members may designate a women's healthcare provider as the medical home PCP.

The medical home PCP is responsible for providing and/or coordinating all healthcare needs for the member, including contacting Moda Health for prior authorization for hospitalizations and specialist care. If the medical home PCP is unavailable, he or she will arrange for another in-network professional provider to assume responsibility for the member’s care. If the member is referred to a specialist who determines hospitalization is needed, the specialist will request the prior authorization.

Members should contact their medical home PCP, identify the network they use, arrange for medical records to be transferred, if needed, and find out how to contact the medical home PCP after office hours. This is the first step in establishing a relationship with the medical home PCP.

3.4 OTHER IN-NETWORK PRIMARY PROVIDER CARE

Members may use any in-network provider when referred to them by the medical home PCP. If members do not use their selected medical home provider for primary care, benefits will be paid at the out-of-network benefit level. A member may see an in-network women’s healthcare provider without referral from the medical home PCP for preventive women's health exams and other gynecological care and for pregnancy care and still receive the in-network benefit level. Members do not need a referral from the medical home PCP for routine exams for men, routine colorectal cancer screening, emergency treatment, naturopathic, chiropractic and acupuncture visits and mental health and/or chemical dependency treatment. However, there are prior authorization requirements for certain services (see section 4.1).

3.5 OUT-OF-NETWORK PROVIDER CARE

Services by an out-of-network provider must be referred by the medical home PCP and not available in-network in order for the in-network benefit level to apply. Moda Health will work with the medical home PCP to refer members to in-network providers whenever possible because these providers have agreed to cooperate in Moda Health’s quality assurance and utilization review programs. Members will be responsible for the copayment or coinsurance and any amount in excess of the maximum plan allowance.

Members do not need a referral from the medical home PCP for preventive women's health exams and mental health and/or chemical dependency treatment. However, there are prior authorization requirements for certain services (see section 4.1).

SECTION 4. COST CONTAINMENT

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

4.1 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.

In-network providers 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 when determined not medically necessary. 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.

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

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. 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 Moda Behavioral Health.

4.1.1 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 emergency hospital admission (or as soon as reasonably possible).

4.1.2 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 prior authorization. Any covered benefit will be based on the cost of the most appropriate setting for the procedure.

4.1.3 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 practice clinical 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.

4.2 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.

4.3 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 5. CARE COORDINATION

5.1 CARE COORDINATION

Care coordination registered nurses work directly with facilities and providers to facilitate prior authorization of scheduled procedures, inpatient stays, and follow-up care as needed for members during urgent or emergent admissions. During the time a member is receiving care or is hospitalized, care coordination nurses may refer them to a case management nurse if they require additional assistance and coordination for complex or catastrophic conditions.

The hospital will call Moda Health to provide notification of all urgent/emergent hospital admissions within 48 hours, or as soon as possible.

Additional information regarding care coordination services is available at myModa under Healthcare coordination.

5.2 CASE MANAGEMENT

Case management is a voluntary service for members experiencing complex conditions or catastrophic events and need assistance from a case management registered nurse or behavioral health specialist. Case managers can help by working with members and their families as patient advocates to:

- Explain and maximize available benefits
- Communicate with providers
- Work with the facility case managers to coordinate discharge plans
- Contact members at home to confirm and support the provider’s treatment plan
- Connect members with community resources

To make a referral to case management, members may contact Moda Health Healthcare Services case management by phone at 503-948-5561 or toll-free at 800-592-8283, by e-mail at casemgmtrefer@modahealth.com, by fax at 503-243-5105, or online at myModa to submit a referral form (available at www.modahealth.com/pdfs/referral_form_case_mgt.pdf). A member can self-refer to case management or be referred by a family member, caregiver, provider or facility staff. To make a referral, please provide the following information:

- Member name and ID number (this can be found on the member’s Moda Health ID card)
- Contact name and number
- Reason for the referral

Once a referral is received, a case manager will evaluate the member’s situation and contact the member within 5 business days.
Additional information regarding case management services is available at myModa under Healthcare coordination.

5.3 DISEASE MANAGEMENT

The Plan provides access to care programs to help members manage a chronic disease or medical condition. The care programs include:

- Cardiac Care
- Dental Care
- Depression Care
- Diabetes Care
- Lifestyle Coaching
- Respiratory Care
- Spine & Joint Care
- Women's Health & Maternity Care

Within these care programs, members work with health coaches to identify their healthcare goals, self-manage their disease and prevent disease progression or complications. Health coaches follow the medical care plan prescribed by the member's professional provider to support health improvement over time.

Members can learn more about Moda Health's disease management care programs at myModa, by calling 503-948-5561 or toll-free at 800-592-8283, or by e-mail at careprograms@modahealth.com.

5.4 WELLNESS PROGRAMS

In addition to the group health plan benefits, value-added wellness programs are available to members to promote health and wellness. Members are encouraged to take part in the following wellness programs:

5.4.1 Weight Watchers Program

Members may participate in the Weight Watchers program up to 4 times a year, provided they participate in the program at least 10 weeks of each 13 week series, with the following options:

a. Traditional Weight Watchers meetings in the community: vouchers for a 13-week session will be mailed to the member's home
b. At Work meetings: members may attend 13-week meetings at their workplace
c. Online subscription: members may participate in a 3-month online subscription with interactive tools and resources
d. For more information visit the website: http://www.oregon.gov/DAS/PEBB/2015Benefits/15WWGateway.pdf

5.4.2 HealthyTEAM HealthyU

Healthy Team Healthy U is an innovative online program that engages members as a team of coworkers in a fun, interactive setting with tools to improve diet, promote physical activities and effect better health. Participation in this program is at no cost to the members and will count as two health actions in the Health Engagement Model (HEM). To learn more about participating in Healthy Team Healthy U visit https://pebb.healthyteam-secure.com/.

5.4.3 Momentum

Members have access to Momentum, a healthy living dashboard, that helps them identify health risks, set goals and see improvements. Members may access Momentum at myModa via modahealth.com and look for the "Momentum, powered by Moda Health" link. Members may also visit Momentum to complete their health assessment as a part of the Health Engagement Model (HEM) Program.

5.4.4 Nurse Advice Line

Members may call the 24-hour Registered Nurse Advice Line at 866-321-7580 for help with medical issues ranging from home-care remedies to recommended emergency care.

SECTION 6. DEFINITIONS

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

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 analysis licensed by BARB and practicing under the supervision of a behavior analyst, and 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.

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 rendered 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 the Plan because of a relationship to a subscriber.

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

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

E-Visits means a consultation for the treatment of a covered medical condition through e-mail with a medical home provider when deemed medically necessary and appropriate by the provider and involves a significant amount of time from the medical home provider's time.

Eligible Employee means any employee or former employee who meets the eligibility requirements to be enrolled under the Plan (see section 9.1).

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.

Enroll means to become covered for benefits under the Plan (that is, when coverage becomes effective) without regard to when the person may have completed or filed any forms that are required in order to become covered. For this purpose, a person who has health coverage is enrolled in the Plan regardless of whether the person elects coverage, the person is a dependent who becomes covered as a result of an election by a subscriber, or the person becomes covered without an election.

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

Exclusion Period means a period during which specified treatments or services are excluded from coverage.

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 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.

The **Group** is PEBB, the organization whose employees are covered by the Plan.

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

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 medical home providers that are contracted under Moda Health to provide care to members.

Look Back Period means the 6-month period of time immediately preceding the actual day of enrollment or if earlier, the beginning of the waiting period.

Maximum Plan Allowance (MPA) is the maximum amount that 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 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 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 facility 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 is no more than the prevailing pharmacy network fee based on the average wholesale price (AWP) accessed by Moda Health minus a percentage discount. Reimbursement for medications dispensed by all other providers will be subject to benefit provisions of the Plan and paid based on the lesser of either 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 considered 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 General Exclusions (Section 8).

Member means a subscriber or dependent of a subscriber who has enrolled for coverage under the terms of the Plan.

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 Plan.

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

Network means a group of providers who contract to provide healthcare to members. 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 are not contracted under Moda Health to provide benefits to members.

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

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

The **Plan** is the health benefit plan sponsored by the Group and insured under the terms of the policy between the Group and Moda Health.

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

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 (see section 4.1).

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. 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
f. Hearing aid specialist
g. Mental health provider as defined above
h. Naturopath
i. 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)
j. Optometrist
k. Physician (doctor of medicine or osteopathy)
l. Physician assistant
m. Podiatrist
n. Registered nurse first assistant
o. Physical, occupational, or speech therapist, but only for rehabilitative services provided upon the written referral of a physician
p. Tobacco cessation program following the United States Public Health guidelines for tobacco use cessation

Provider means an entity, including but not limited to 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, including Baker, Gilliam, Grant, Harney, Lake, Malheur, Morrow, Sherman, Umatilla, Union, Wallowa and Wheeler counties, where in-network providers provide their services.

Subscriber means any employee, former employee or retiree who is enrolled in the Plan.

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.

Waiting Period means the period that must pass before a person is eligible to enroll for benefits under the terms of the Plan.

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

A member may see an in-network women’s healthcare provider without referral from her PCP for preventive women’s health exams and other gynecological care, and for pregnancy care. Follow-up visits and all necessary treatment related to this routine examination are eligible if the services are covered by the Plan (including x-rays, laboratory tests or surgery).

SECTION 7. BENEFIT DESCRIPTION

The Plan covers services and supplies listed when medically necessary for diagnosis and/or treatment of a medical condition, as well as certain preventive services. 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 (see section 4.1).

Members should present their identification cards and make the appropriate copayments as listed in the Schedule of Benefits (section 2.2) before they receive care.

7.1 MEMBERSHIP CARD

After enrollment, members will receive identification cards that will include the group and identification numbers. Members will need to present the cards (also available in the electronic and mobile format) each time they receive services. Members may go to myModa or contact Customer Service for replacement of a lost identification card.

7.2 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 the Plan
b. Has applied for coverage and has been accepted
c. Has had his or her premiums for the current month paid by the Group on a timely basis

If a member is a hospital inpatient on the day the policy with the Group is terminated, the Plan will continue to pay claims for covered services for that hospitalization until the member is discharged from the hospital.

7.3 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 9-1-1 or seek care from the nearest appropriate provider, such as a physician's office or clinic, urgent care facility or emergency room.

Prior authorization is not required for emergency services, including emergency medical screening exams or treatment to stabilize an emergency medical condition, when a prudent layperson possessing an average knowledge of health and medicine would reasonably believe that the failure to receive immediate medical attention would place the health of the member, or a fetus in the case of a pregnant woman, in serious jeopardy.

Claims for emergency care will be paid at the in-network benefit level, even without a referral by the PCP or authorization by Moda Health. However, out-of-network providers may bill members for charges in excess of the maximum plan allowance. Emergency care rendered by a provider other than the PCP should be reported to the PCP within 24 hours of initial treatment, or as soon as possible. When the PCP is out of the office, another medical home professional provider will be on call to assist members (see section 7.4 for more information). The emergency room facility copayment applies to services billed by the facility. Professional fees (e.g., emergency room physician, or x-ray/lab) billed separately are subject to the standard in-network benefit level. If a covered hospitalization immediately follows emergency services, emergency room facility copayments will be waived. All other applicable cost sharing remains in effect.

7.3.1 Emergencies Within the Service Area

Medical home PCPs are available 24 hours a day, 7 days a week. When members are uncertain if they have an emergency medical condition, they should contact their medical home PCP, who will advise if they should seek emergency care at the nearest facility.

Certain medical emergencies may prevent members from initially seeking care through their medical home PCP. If a member requires immediate medical assistance due to an emergency medical condition, and believes the delay caused by contacting the medical home PCP will jeopardize their health, they should seek care from the nearest appropriate facility or call 9-1-1. They should call the medical home PCP within 24 hours of the initial medical care, or as soon thereafter as possible.

7.3.2 Emergencies and Urgent Care Outside the Service Area

If members are outside of the service area and a medical emergency occurs, they should seek medical attention from the nearest appropriate facility or call 9-1-1. They should notify their medical home PCP within 24 hours after initial treatment, or as soon as reasonably possible. Follow-up care will not be reimbursed at the in-network benefit level unless they are referred by their medical home PCP.

If a member's condition requires hospitalization in an out-of-network facility, his or her medical home PCP 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 medical home PCP 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, unless a member's medical home primary care provider has requested a prior authorization that has been approved by Moda Health, and service is not available in the Moda Health network. The following are not emergency medical conditions and are not eligible for the in-network benefit level (this list is not inclusive of all such services):

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

7.3.2 Emergency Eye Care Services

The Plan covers eye care services provided by an optometrist, an ophthalmologist or a hospital emergency room for emergency medical conditions without a referral or prior authorization from a medical home primary care provider.

7.4 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 4.1). Failure to obtain required prior authorization may result in denial of benefits.

7.4.1 Emergency Room Care

Medically necessary emergency room care is covered. See section 7.3 for more information.

The emergency room facility benefit applies to services billed by the facility. Professional fees (e.g., emergency room physician, or x-ray/lab) billed separately are subject to the standard in-network benefit level.

7.4.2 Pre-admission Testing

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

7.4.3 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 the Plan 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 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 in-nursery physician's visits of a well newborn infant while the mother is confined in the hospital and receiving maternity benefits under the Plan.
g. **Observation care.** Including the use of a bed and periodic monitoring for 24 to 48 hours.

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.

7.4.4 Inpatient Rehabilitative Care

Covered rehabilitative 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 following head or spinal cord injury, or for treatment of a stroke, subject to medical necessity and prior authorization. These benefits are payable only when a member's condition requires inpatient rehabilitative hospital care. 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.

7.4.5 Skilled Nursing Facility Benefits

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

Covered skilled nursing facility days are subject to an annual limit and medical necessity. 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 enrolled in the Plan or for a stay where care is provided principally for:

a. Senile deterioration
b. Alzheimer's disease
c. Mental deficiency or intellectual disability in members age 18 or older
d. Mental illness

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

7.4.6 Residential Mental Health and Chemical Dependency Treatment Programs

All-inclusive per diem 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.

7.4.7 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.

7.5 AMBULATORY SERVICES

Many ambulatory services require prior authorization.

7.5.1 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.

7.5.2 Outpatient Rehabilitation

Rehabilitative 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 and are necessary to restore or improve lost function caused by a medical condition. Rehabilitative services are subject to an annual limit. 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 cardiac rehabilitation and outpatient services for mental health and chemical dependency are not subject to this limit.

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, services related to treatment, testing or training or hippotherapy.

7.5.3 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.

Home infusion therapy must be provided by an accredited home infusion therapy agency. In addition, members receiving the services must qualify as "homebound" (as defined in section 7.7.9.)

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

7.5.4 Diagnostic X-rays and Laboratory Tests
The Plan covers diagnostic x-rays and laboratory tests related to treatment of a medical condition.

7.5.5 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

7.5.6 Imaging Procedures
The Plan covers all standard imaging procedures related to treatment of a medical condition.

The following advanced imaging services require prior authorization:

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. Nuclear cardiology studies

7.5.7 Outpatient Chemical Dependency Services
Services for assessment and treatment of chemical dependency in an outpatient treatment program are covered. Treatments involving the use of Methadone are covered when such treatment is part of a medically supervised treatment program.

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

7.5.8 Routine Costs in Clinical Trials
Routine costs for the care of a member who is enrolled in or participating in an approved clinical trial through an in-network provider 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. The Plan is not liable for any adverse effects of the clinical trials.

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

7.5.9 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.

7.5.10 Genetic Testing and Counseling Services

Genetic studies and counseling for the purpose of diagnosis or aid in treatment planning are covered and prior authorization is required. Identification of a genetic disorder should result in medical interventions and solutions that are corrective or therapeutic in nature.

7.6 PROFESSIONAL PROVIDER SERVICES

7.6.1 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/uspsabrecs.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.

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 purpose of travel are covered when recommended by the Disease Control and Prevention (CDC), but for the sole purpose 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.

   A woman may see a women's healthcare provider without referral from her medical home PCP for preventive women's health exams. If a women's healthcare provider recommends follow-up visits resulting from an exam covered under this provision, the follow-up visits do not need to be referred by the member's medical home primary care provider. However, the follow-up visits and related treatment are eligible only if the services are covered (this includes x-rays, laboratory tests or surgery). The women's healthcare provider should keep the medical home primary care provider informed of the medical care being provided.

f. Routine Prostate Rectal Exam & Prostate Specific Antigen (PSA) Test. 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 professional provider and are paid at the medical benefit level if outside the preventive screening age and frequency limits.

h. Preventive services for members with diabetes:

i. A dilated retinal exam every year
ii. A glycosylated hemoglobin (HbAlc) test; urine test to test kidney function; blood test for lipid levels as appropriate; visual exam of mouth and teeth

7.6.2 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.

7.6.3 Home, Office or Hospital Visits (including Urgent Care Visits)

A "visit" means the member is actually examined by a professional provider, including naturopathic, chiropractic and acupuncture visits. Covered expenses include consultations with written reports, as well as second opinion consultations. Ancillary services (such as lab tests) received in conjunction with the office visits are subject to the standard cost sharing.

7.6.4 Electronic Visits (E-Visits)

An electronic visit (e-visit) is a structured, secure online consultation between the professional provider and the member. The Plan covers e-visits when the following conditions are met:

a. The member has previously been treated in the professional provider's office within the last 12 months and is established as a patient
b. The e-visit is medically necessary for a covered medical condition

E-mail communications including those to renew prescriptions, schedule tests or appointment, report normal test results, recommend a referral to another physician, follow up an office visit, confirm stability of a chronic problem and continuity of present management of the problem, or communicate information related to mental health or chemical dependency services, are not covered.

7.6.5 Telemedical Health Services

Covered medical services, when generally accepted healthcare practices and standards determine they can be safely and effectively provided using synchronous a 2-way interactive

video conference , are covered when provided 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.

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.

7.6.6 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. 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.

7.6.7 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 sections 7.8.1 and 7.9.6).

Vitamin and mineral injections are not covered unless medically necessary for treatment of a specific medical condition.

7.6.8 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

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

Prior authorization is required for additional cost tier services including bunionectomy, hammertoe surgery, knee viscosupplementation, Morton’s neuroma, spinal injections for pain, upper gastrointestinal endoscopy, knee arthroscopy, knee or hip replacement, knee or hip resurfacing, shoulder arthroscopy, sinus surgery, spine procedures and bariatric surgery. The additional cost tier does not apply to covered expenses related to cancer diagnoses or treatment to tissue injuries resulting from an external force which require immediate repair.

7.6.9 Reconstructive Surgery Following a Mastectomy

As used in this section, mastectomy means the surgical removal of all or part of a breast, including a breast tumor suspected to be malignant. 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.

The information in this section is provided in accordance with Oregon statute, which requires notice of coverage for mastectomy related services.

7.6.10 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 7.6.9.

7.6.11 Gender Identity Disorder/Gender Dysphoria
To be eligible for coverage, all services must be Medically Necessary.

Coverage includes:
a. Mental health
b. Hormone therapy (including puberty suppression therapy for adolescents)
c. Surgical procedures

The Plan covers expenses for gender reassignment under the following conditions:
a. The procedure(s) must be performed by a qualified professional provider
b. The professional provider must obtain prior authorization for the surgical procedure
c. The treatment plan must meet medical necessity criteria
d. Covered procedures include:
    i. Breast/chest surgery for female-to-male (FtM)
    ii. Gonadectomy (hysterectomy/oophorectomy for FtM or orchiectomy for MtF)
    iii. Single stage or multiple stage reconstruction of the genitalia

The following services are **excluded** from coverage by the Plan as part of gender identity disorder treatment:

a. Rhinoplasty
b. Face-lifting
c. Lip enhancement
d. Facial bone reduction
e. Blepharoplasty/brow Lift
f. Breast augmentation
g. Liposuction/abdominoplasty of the waist (body contouring)
h. Reduction of thyroid chondroplasty
i. Hair removal
j. Voice modification surgery (laryngoplasty or shortening of the vocal cords)
k. Skin resurfacing used in feminization
l. Chin implants/Cheek Implants
m. Nose implants
n. Lip reduction
o. Collagen injections
p. Reversal, revision, or removal of gender reassignment surgery
q. Make up evaluation
r. Voice training
s. Legal expenses related to name change
t. Travel and lodging expenses

7.6.12 Cochlear Implants

Cochlear implants are covered when medically necessary and prior authorized.

7.6.13 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.

7.6.14 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 of 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 enrolled in the Plan

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, including bridges, implants and implant related services.-Exceptions to the timelines may be made when medically necessary.

7.6.15 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.

7.6.16 Temporomandibular Joint Syndrome (TMJ)

TMJ related services are covered including:

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

TMJ related surgery and treatment of related dental diseases or injuries, such as dental or orthodontia services, are excluded.

7.6.17 Mental Health

The Plan covers medically necessary outpatient services by a mental health provider as defined in section 6.

Behavioral Health Customer Service can help members locate in-network providers and understand the mental health benefits.

7.6.18 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).

7.6.19 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, medications and medical supplies 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 an exclusive tobacco cessation program.

7.6.20 Spinal Manipulation and Acupuncture Care

Spinal manipulation and acupuncture are covered, subject to an annual maximum. Reimbursement for other services is at the Plan's standard cost sharing for the type of service provided. 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.

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

Coverage for autism spectrum disorder treatment 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, telemedicine, music therapy, neurofeedback, chelation or hyperbaric chambers
c. Services provided under an individual education plan in accordance with the Individuals with Disabilities Education Act, 20 U.S.C 1400 et seq
d. Services provided by the Department of Human Services or the Oregon Health Authority, other than employee benefit plans offered by the department and the authority

7.7 OTHER SERVICES

7.7.1 Ambulance Transportation (Including Emergency Medical 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.

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

7.7.2 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 the 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 intermittent 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 by Moda Health. Benefits are provided 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 8, the following are not covered:

i. Hospice services provided to other than the terminally ill member, including 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

7.7.3 Maternity Care

Prenatal care, and postnatal care, childbirth and related conditions such as complications of pregnancy and delivery, 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 8. Supportive services, such as physical, emotional and informational support to the mother before, during and after birth and during the postpartum period, are not covered expenses.

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

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.

7.7.4 Breastfeeding Support

Comprehensive lactation support and counseling is covered during pregnancy and/or the postpartum period. The Plan covers the 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.

7.7.5 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 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 of 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 limitations and 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 the Plan, 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 the Plan and the recipient is not enrolled or is in the exclusion period, the Plan will not pay any benefits toward donor costs. Expenses incurred by a donor that result from complications and unforeseen effects of the donation are covered for a period not to exceed 30 consecutive days following the surgery. "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 expenses are subject to a $5,000 combined maximum for transportation, food and lodging. Food and lodging is also subject to a $150 daily limit.

iv. Professional provider transplant services are paid according to the benefits for professional providers;
v. Immunosuppressive drugs provided during a hospital stay are paid as a medical supply. Outpatient oral and self-injectable prescription medications for transplant related services are paid under the Pharmacy Prescription Medication section 7.9).
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.

d. 24-Month Exclusion Period. Transplants will not be covered during the first 24 months a person is enrolled in the Plan. The 24-month exclusion period will not apply if the member:
   i. has had continuous health coverage since birth or placement for adoption
   ii. was continuously enrolled in the Plan together with the Group's prior plan at least 24 months prior to incurring transplant related expenses. Each day of creditable coverage the member had under that prior health benefit plan will reduce the 24-month exclusion period by one day

Moda Health will use the following sources to determine creditable coverage: information given on the enrollment application, information from prior group health plans and insurers, and other available evidence. Any period of creditable coverage that is followed by a break in coverage of 63 days or more cannot be used to reduce the exclusion period. Any coverage waiting period imposed under a group health plan or policy, and any affiliation period imposed by an HMO, will not be counted toward the break in coverage.

7.7.6 Bariatric Surgery

In-network medically necessary bariatric surgery services, limited to gastric bypass, gastric stapling, gastroplasty, gastric sleeve, and the Lap-Band adjustable gastric banding system, are covered for members who meet all of the following requirements:

a. Meet the clinical criteria including body mass index (BMI) equal to or greater than 35 with a diagnosis of diabetes, BMI equal to or greater than 40 with any obesity related comorbid condition such as obstructive sleep apnea, treated hypertension, treated diabetes or cardiac disease), or BMI equal to or greater than 50 with or without obesity related comorbid conditions
b. Complete a 6-month work up that includes dietary counseling and education, medical and psychological evaluation and a weight loss of greater than 5% during the work up period
c. Prior authorize and obtain approval after the 6-month work up period
d. Services must be received at a center of excellence facility that
   a. Moda Health has arranged or contracted with to provide bariatric surgery and
   b. meets the Health Evidence Review Commission guidelines for facilities providing bariatric surgery

7.7.7 Infertility Services

Infertility is defined as the inability to become pregnant or the inability to carry a pregnancy to term as evidenced by 3 consecutive spontaneous miscarriages. The Plan covers infertility services including:

a. Diagnostic testing and related office visits to determine the cause of infertility.
b. Examination, related laboratory testing, and medical and surgical procedures to treat infertility
c. Artificial insemination, limited to a lifetime maximum of 6 cycles and sperm wash
d. Acquisition cost for semen
e. Infertility related medications or injectables
f. Covered infertility-related supplies

The Plan does not cover donor semen from donor banks or other providers, harvesting and storage of semen other than for immediate use, infertility services not resulting from a medical condition, services for unenrolled surrogate mothers, infertility resulting from the aging process, and in vitro and in vivo fertilization (including services related to or supporting in vitro fertilization, GIFT, ZIFT, reversals of voluntary sterilization and procedures determined to be experimental or investigational.

7.7.8 Biofeedback

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

7.7.9 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 a 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, or supplies provided as part of a hospice treatment plan. These are covered under sections 7.7.2 and 7.7.9.

There is a 2-visit maximum allowed in any one day for the services of a registered or licensed practical nurse. All other home healthcare providers are limited to one visit per day. Home health visits are also subject to a calendar year maximum. Home healthcare requires prior authorization.

7.7.10 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 bras 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. However, 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, eye glasses and contact lenses except as otherwise covered by the Plan.

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.

Replacement or repair
Only covered if the appliance, prosthetic device, 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 8, the Plan will not cover the following appliances and equipment, even if they relate to a condition that is otherwise covered by the Plan:

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 8)
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.

7.7.11 Hearing Exams and Hearing Aids
The Plan covers one hearing exam every year and one hearing aid per hearing impaired ear every 48 months. 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

7.7.12 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.

7.8 MEDICATIONS

7.8.1 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 X.

See section 7.9 for pharmacy benefits.

7.8.2 Anti-cancer Medication

Prescribed anticancer medications, including oral, intravenous (IV) or injected medications are covered. Anti-cancer medications require prior authorization and may be subject to specific benefit limitations. Self-administered medications require delivery by an exclusive specialty pharmacy (see section 7.9.5). 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 7.5.3 and 7.9.6.

7.9 PHARMACY PRESCRIPTION MEDICATION BENEFIT

7.9.1 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.

Formulary. A formulary is a listing of all prescription medication sand their coverage under the prescription medication benefit. A formulary look up tool is available on myModa under the pharmacy tab. This online formulary tool provides coverage information, treatment options and price quotes for many medications.

Generic Medications. Generic medications have been determined by physicians and pharmacists to be therapeutically equivalent to the brand alternative and are often 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.

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 and medically necessary.

Value 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 Health.

7.9.2 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 Plan
c. The prescribed medication is not excluded

7.9.3 Covered Medication Supply

A 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. Legend contraceptive medications and devices for birth control (section 7.6.2) and medical conditions covered under the Plan
f. 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
g. Select immunizations (section 7.6.1) 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 4.1.3). For assistance coordinating prescription refills, contact Pharmacy Customer Service.

7.9.4 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 from the Group, on myModa or by contacting Customer Service.

7.9.5 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 drug 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.

7.9.6 Self Administered Medication

All self-administered medications are subject to the pharmacy prescription medication requirements of section 7.9. Self-administered specialty medications are subject to the same requirements as other specialty medications (section 7.9.5). 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.

7.9.7 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.

7.9.8 Limitations

To ensure appropriate access to drugs, 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 and specialty 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. Coverage of weight loss drugs is subject to review and will be covered if medical necessity is determined for the medical treatment of weight-loss or obesity under the Plan.
e. 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.
f. 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.
g. Claims for medications purchased outside of the United States and its territories will only be covered in emergency and urgent care situations.
h. Early refill of medications for travel outside of the United States is subject to review and when allowed is limited to once every 6 months.

7.9.9 Exclusions

In addition to the exclusions listed in Section 8, the following medication supplies are not covered by the Plan.

a. **Cosmetic.** Medications, including hormones, prescribed or used for cosmetic purposes.
b. **Devices.** Including, but not limited to therapeutic devices and appliances. Information for contraceptive devices is in section 7.6.2 and for other devices in section 7.7.10
c. **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

d. **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
e. **Hair Growth Medications.**
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 retail pharmacies.
h. **Medications Covered Under Another Benefit.** Such as medications covered under home health, medical, etc.
i. **Non-Covered Condition.** A medication prescribed for purposes other than to treat a covered medical condition
j. **Nutritional Supplements and Medical Foods.**
k. **Off-label Use.** Medications prescribed for or used for non-FDA approved indications, unless approved by the Health Resources Commission
l. **Over the Counter (OTC) Medications** and prescription medications for which there is an OTC equivalent or alternative
m. **Repackaged Medications.**
n. **Replacement Medications and/or Supplies.**

7.9.10 Choice 90 Program

Choice 90 is a program that allows members to purchase a 90-day supply from a participating Choice 90 retail pharmacy. Certain drugs are not available in 90-day supplies for such reasons as quantity limit restrictions or state and federal regulations. Choice 90 benefits apply for supplies of 84 days and greater. All other standard benefit plan and administrative provisions apply. To find Choice 90 participating pharmacies, members should select "Choice 90" when searching for participating pharmacies through myModa.

SECTION 8. GENERAL EXCLUSIONS

In addition to the limitations and exclusions described elsewhere in the Plan, 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 handbook 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
Except when required under the Plan's coordination of benefits rules (see Section 11).

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 7.6.9); or as part of gender identity services (section 7.6.11).

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 7.6.14 and 7.6.10, 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 7.7.11.

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
Donor semen from donor banks or other providers, harvesting and storage of semen other than for immediate use, infertility services not resulting from a medical condition, services for unenrolled surrogate mothers, infertility resulting from the aging process, and in vitro and in vivo fertilization (including services related to or supporting in vitro fertilization, GIFT, ZIFT, reversals of voluntary sterilization and procedures determined to be experimental or investigational.

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 will 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.

Missed Appointments

Naturopathy

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.

Obesity or Weight Reduction
Except as covered in section 7.7.6.

Orthopedic Shoes
Except as provided for in section 7.7.10.

Orthognathic Surgery
Including associated services and supplies.

Pastoral and Spiritual Counseling

Physical Examinations
Physical examinations for administrative purposes, such as employment except when required to obtain a commercial driver license in Oregon, 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 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. provided under separate contracts that are used to provide coordinated coverage for covered persons in a group and are considered parts of the same plan
e. 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 rendered 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 that are not service related are eligible for payment according to the terms of the Plan.

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

Services Provided by Volunteer Workers

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

Support Education
Including the following:

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 Plan. 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 7.6.4 and 7.6.5.

Telephones and Televisions in a Hospital or Skilled Nursing Facility

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, financial, 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
The only exception is if a member is hospitalized at the time the Plan terminates (see section 7.2), or 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 under the Plan or are prescribed for purposed 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 or residential chemical dependency treatment program when an appropriate level of treatment could be delivered in an outpatient setting such as an ambulatory surgery facility or outpatient chemical dependency treatment program

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 under the Plan began. Reimbursement for such admission will be the responsibility of the plan under which the member was covered immediately preceding and extending up to the effective date of the Plan. If no such plan was in effect, Moda Health will provide coverage only for those covered expenses incurred on or after the member's effective date under the Plan.

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 Plan.

Vitamins and Minerals
Unless medically necessary for treatment of a specific medical condition and only if they bear the legend "Caution – Federal law prohibits dispensing without a prescription" and a dosage form of equal or greater strength of the medication is not available without a prescription under federal law. This applies whether the vitamin or mineral is oral, injectable, or transdermal.

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 the Group does not provide workers' compensation coverage to them.

Notwithstanding the scope of exclusions mentioned above, the following services, procedures and conditions are not covered, even if they relate to a condition that is otherwise covered by the Plan, or if recommended, referred, or provided by a provider, unless they meet Moda Health medical necessity criteria.

Breast Reduction

Varicose Vein Surgery, Ablation or Stripping

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

Wrist Ganglion Cyst Surgery

SECTION 9. ELIGIBILITY AND ENROLLMENT

This section outlines who is eligible for coverage and the related enrollment procedures that apply to eligible PEBB employees and eligible dependents. Benefits are not available to anyone who is not properly enrolled in the Plan.

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

9.1 PEBB SUBSCRIBER ELIGIBILITY AND ENROLLMENT

PEBB employees are eligible for coverage as specified in the eligibility or coverage continuation provisions established by PEBB. The PEBB eligibility rules are governed under provisions of the Oregon Administrative Rules, Chapter 101. Employees or retirees should refer to the PEBB eligibility rules and the PEBB Summary Plan Description for detailed information on eligibility and program requirements.

9.2 DEPENDENT ELIGIBILITY AND ENROLLMENT

Eligible dependent means a person who is eligible for coverage by a PEBB employee as specified in the eligibility or coverage continuation provisions established by PEBB. The PEBB eligibility rules are governed under provisions of the Oregon Administrative Rules, Chapter 101. Employees or retirees should refer to the PEBB eligibility rules and the PEBB Summary Plan Description for detailed information on eligibility and program requirements.

Employees must enroll their eligible dependents in accordance with the requirements established by PEBB. No eligible dependent will become a member until PEBB approves that eligible dependent for coverage. The PEBB eligibility rules are governed under provisions of the Oregon Administrative Rules, Chapter 101. Employees or retirees should refer to the PEBB eligibility rules and the Summary Plan Description for detailed information on eligibility and program requirements.

A subscriber's newborn or adopted child who meets the definition of a PEBB eligible dependent is eligible for enrollment from the date of birth or placement for the purpose of adoption. The PEBB eligibility rules are governed under provisions of the Oregon Administrative Rules, Chapter 101. Employees or retirees should refer to the PEBB eligibility rules and the PEBB Summary Plan Description for detailed information on eligibility and program requirements.

9.3 SPECIAL ENROLLMENT PERIODS

If coverage is declined when initially eligible, an eligible employee or any dependent(s) may enroll in the Plan during a special enrollment period. The PEBB eligibility rules are governed under provisions of the Oregon Administrative Rules, Chapter 101. Employees or retirees should refer to the PEBB eligibility rules and the PEBB Summary Plan Description for detailed information on eligibility and program requirements.

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

9.4 Eligibility Audit

Moda Health reserves the right to conduct audits to verify a member's eligibility, and may request documentation including but not limited to employee timecards, member birth certificates, adoption paperwork, marriage certificates, domestic partnership registration and any other evidence necessary to document eligibility on the Plan.

SECTION 10. CLAIMS ADMINISTRATION & PAYMENT

10.1 SUBMISSION AND PAYMENT OF CLAIMS

In no event, except absence of legal capacity or in the case of a Medicaid claim, is a claim valid if submitted later than 12 months from the date the expense was incurred. Claims submitted by Medicaid must be sent to Moda Health within 3 years after the date the expense was incurred.

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 that might not be covered by the Plan. If this happens, the member must pay these amounts. Moda Health will reimburse the member if any of the charges paid are later determined to be covered by the Plan.

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 group and identification numbers
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 and the member’s name, group number, and identification number.

10.1.3 Tobacco Cessation Program Claims

Moda Health will be billed directly by the tobacco cessation program for the cost of counseling, consultation and supplies. Other providers may require a member to pay the charges and submit the claim to Moda Health. If this happens, the member should submit a request for reimbursement. Prescription tobacco 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 any. 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.

10.1.7 Time Frames for Processing Claims
If a claim is denied, Moda Health will send an EOB explaining the denial within 30 days after receiving the claim. If additional time is needed to process the claim for reasons beyond Moda Health's control, a notice of delay will be sent to the member explaining those reasons within 30 days after Moda Health receives the claim. Moda Health will then complete its processing and send an EOB to the member no more than 45 days after receiving the claim. If additional information is needed to complete processing of the claim, the notice of delay will describe the information needed and the party responsible for providing the additional information will have 45 days to submit it. Once the additional information is received, processing of the claim will be completed within 15 days. Submission of information necessary to process a claim is subject to the Plan's claim submission period explained in section 10.1.

If a service must be authorized for a member to receive maximum plan benefits, Moda Health will respond to the prior authorization request within 2 business days. The response time will be expedited if the member has an urgent medical condition.

10.1.1 Time Frames for Processing Prior Authorizations and Utilization Reviews
Any utilization review decision will be made within 2 business days after receipt of the request for prior authorization of nonemergency situations. For emergency situations, utilization review decisions for care following emergency services will be made as soon as is practicable but in any event no later than 24 hours after receiving the request for prior authorization or for coverage determination.

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

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

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

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

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 an initial written appeal. If an appeal is not submitted within the timeframes outlined in this section, the rights to the appeals process will be lost.

10.2.3 The Review Process

The Plan has a 2-level internal review process consisting of a first level appeal and a second level appeal. If a member is not satisfied with the outcome of the second level appeal, and the dispute meets the specifications outlined in section 10.2.6, the member may request external review by an independent review organization. The first and second levels of appeal must be exhausted to proceed to external review, unless Moda Health agrees otherwise.

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).

A 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.

10.2.4 First Level Appeals

Before filing an appeal, 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. Moda Health will acknowledge receipt of the written appeal within 7 days and conduct an investigation by persons who were not involved in the original determination.

Appeals related to an urgent care claim will be entitled to expedited review upon request. Expedited reviews will be completed within 72 hours in total for the first and second level appeals combined after receipt of those appeals by Moda Health, not counting the lapse between the first level appeal determination and receipt of the second level appeal by Moda Health. If the member fails to provide sufficient information for Moda Health to make a decision at each appeal level, 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 must provide the specified information as soon as possible.

When an investigation has been completed, 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 a second level appeal. This notice will be sent within 15 days of a pre-service appeal or 30 days of a post-service appeal.

10.2.5 Second Level Appeals

A member who disagrees with the decision regarding the first level appeal may request a review of the decision. The second level appeal must be submitted in writing within 60 days of the date of Moda Health's action on the first level appeal.

Investigations and responses to a second level appeal will be by persons who were not involved in the initial determinations, and will follow the same timelines as those for a first level appeal. 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.

10.2.6 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 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 sections 10.2.4 and 10.2.5. 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 a 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.

Moda Health will notify the Oregon Insurance Division of a member's request for external review no later than the second business day after receipt of the request and will pay the cost of the external review. The member may submit additional information to the independent review organization no later than 5 business days after the appointment of the review organization or 24 hours in the case of an expedited review. The independent review organization will complete their review within:

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

The decision of the 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 Plan does not qualify for external review. A complaint decision does not qualify for external review.

10.2.7 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.

10.2.8 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: Oregon Insurance Division
P.O. 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 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 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 requests 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 Plan 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 leaves the Plan or if the Group discontinues the Plan 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 the Plan is required to provide to the 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 11.

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 Plan 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 to Moda Health 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 Plan.

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 health care 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.

f. 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.

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

10.4.2.4 Additional Provisions

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

a. The member shall cooperate with Moda Health to protect its recovery rights, including by:

    i. Signing and delivering any documents Moda Health reasonably requires to protect its rights, including a Third Party Reimbursement Questionnaire and Agreement. If the member has retained an attorney, then the attorney must also sign the agreement. The Plan will not be required to pay benefits until the agreement is properly signed and returned

ii. Providing any information to Moda Health relevant to the application of the provisions of section 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 the Plan may issue benefits. The member has this responsibility even if the first request for payment of benefits is a bill or invoice submitted to Moda Health by the member's provider
iv. Taking such actions as Moda Health may reasonably request to assist it in enforcing its third party recovery rights

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

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

d. The member agrees that Moda Health may notify any third party, or third party's representatives or insurers, of its recovery rights described in section 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, the Plan will provide benefits for the continuing treatment of that medical condition only to the extent that the member can establish that any sums that may have been recovered from the third party have been exhausted.

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

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

10.5 MEDICARE

The Plan coordinates benefits with Medicare Part A and B as required under federal government rules and regulations. 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, if the Plan is secondary to Medicare, Moda Health will 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 11. 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 trusteed 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.

An **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 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.

A **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 Moda Health 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 two plans is reversed.
b. **Dependent Child/Parents Married or Living Together.** If the member is a dependent child whose parents are married, domestic partners, 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:
        A. The plan covering the custodial parent
        B. The plan covering the spouse or domestic partner of the custodial parent
        C. The plan covering the non-custodial parent
        D. The plan covering the 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 Coverage 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 plan 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).

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 12. MISCELLANEOUS PROVISIONS

12.1 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.

12.2 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.

12.3 TRANSFER OF BENEFITS

Only members are entitled to benefits under the Plan. 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 upon a member's written request.

12.4 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.

12.5 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.

12.6 CONTRACT PROVISIONS

The policy between Moda Health and the Group and this handbook plus any endorsements or amendments are the entire contract between the parties. No promises, terms, conditions or obligations exist other than those contained in the contract. This handbook and the 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.

12.7 REPLACING ANOTHER PLAN

For persons covered on an earlier Moda Health or other group plan that this Plan replaces, provided they remain eligible for coverage according to the requirements of the Plan, Moda Health will apply the benefits under the Plan reduced by any benefits payable by the prior plan. This replacement provision does not apply to any person excluded from coverage under the Plan because the person is otherwise covered under another policy with similar benefits.

The Plan shall give credit for the satisfaction or partial satisfaction of any deductibles met under the prior plan for the same or overlapping benefit periods with the Plan, but the credit shall apply or be given only to the extent that the expenses are recognized under the terms of the Plan and are subject to a similar deductible provision.

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

12.10 NO WAIVER

Any waiver of any provision of the Plan, or any performance under the Plan, must be in writing and signed by the waiving party. Any such waiver shall not operate as, or be deemed to be, a waiver of any prior or future performance or enforcement of that provision or any other provision. If Moda Health delays or fails to exercise any right, power or remedy provided in the Plan, including, a delay or omission in denying a claim, that shall not waive Moda Health's rights to enforce the provisions of the Plan.

12.11 GROUP IS THE AGENT

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

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 the Plan. This includes compliance with federal mental health parity requirements.

12.13 GOVERNING LAW

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

12.14 WHERE ANY LEGAL ACTION MUST BE FILED

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

12.15 TIME LIMITS FOR FILING A LAWSUIT

Any legal action arising out of, or related to, the Plan and filed against Moda Health by a member or any third party, must be filed in court no more than 3 years after the time the claim was filed (see section 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 13. CONTINUATION OF HEALTH COVERAGE

The following sections on continuation of coverage may apply. Members should check with the Group to find out whether they qualify for this coverage. Both subscribers and their dependents should read the following sections carefully.

13.1 OREGON CONTINUATION FOR SPOUSES & DOMESTIC PARTNERS AGE 55 AND OVER

13.1.1 Introduction

55+ Oregon Continuation only applies to employers with 20 or more employees. Moda Health will provide 55+ Oregon Continuation coverage to those members who elect it, subject to the following conditions:

a. Moda Health will offer no greater rights than ORS 743.600 to 743.602 requires
b. Moda Health will not provide 55+ Oregon Continuation coverage for members who do not comply with the requirements outlined below
c. The Group or its designated third party administrator is responsible for providing the required notices within the statutory time periods, including the notice of death and the election notice. If the Group or its designated third party administrator fails to notify the eligible spouse or domestic partner, premiums shall be waived from the date the notice was required until the date notice is received by the spouse or domestic partner. The Group shall be responsible for such premiums

13.1.2 Eligibility

The spouse or domestic partner of the subscriber may elect 55+ Oregon Continuation coverage for himself or herself and any enrolled dependents if the following requirements are met:

a. Coverage is lost because of the death of the subscriber, dissolution of marriage or domestic partnership with the subscriber, or legal separation from the subscriber
b. The spouse or domestic partner is 55 years of age or older at the time of such event
c. The spouse or domestic partner is not eligible for Medicare

13.1.3 Notice and Election Requirements

Notice of Divorce, Dissolution, or Legal Separation. Within 60 days of legal separation or the entry of a judgment of dissolution of marriage or domestic partnership, a legally separated or divorced spouse or domestic partner who is eligible for 55+ Oregon Continuation and seeks such coverage shall give the Group or its designated third party administrator written notice of the legal separation or dissolution. The notice shall include his or her mailing address.

Notice of Death. Within 30 days of the death of the subscriber whose surviving spouse or domestic partner is eligible for 55+ Oregon Continuation, the Group shall give the designated third party administrator, if any, written notice of the death and the mailing address of the surviving spouse or domestic partner.

Election Notice. Within 14 days of receipt of the above notice (or within 44 days of the death of the subscriber if there is no third party administrator), the Group or its designated third party administrator shall provide notice to the surviving, legally separated or divorced spouse or

domestic partner that coverage can be continued, along with an election form. If the Group or its designated third party administrator fails to provide this election notice within the required timeframe, premiums shall be waived until the date notice is received.

Election. The surviving, legally separated or divorced spouse or domestic partner must return the election form within 60 days after the form is mailed. Failure to exercise this election within 60 days of the notification shall terminate the right to continued benefits under this section.

13.1.4 Premiums

Monthly premiums for 55+ Oregon Continuation are limited to 102% of the premiums paid by a current subscriber. The first premium shall be paid by the surviving, legally separated or divorced spouse or domestic partner to the Group or its designated third party administrator within 45 days of the date of election. All remaining monthly premiums must be paid within 30 days of the premium due date.

13.1.5 When Coverage Ends

55+ Oregon Continuation will end on the earliest of any of the following events:

a. Failure to pay premiums when due, including any grace period allowed by the Plan
b. The date the Plan terminates, unless a different group policy is made available to members
c. The date the member becomes insured under any other group health plan
d. The date the member remarries or registers another domestic partnership and becomes covered under another group health plan
e. The date the member becomes eligible for Medicare

13.2 COBRA CONTINUATION COVERAGE

13.2.1 Introduction

COBRA only applies to employers with 20 or more employees on 50% of the typical business days in the prior calendar year. Certain church plans are exempted from COBRA. Moda Health will provide COBRA continuation coverage to members who have experienced a qualifying event and elect coverage under COBRA, subject to the following conditions:

a. Other than the exception on domestic partner coverage, Moda Health will offer no greater COBRA rights than the COBRA statute requires;
b. Moda Health will not provide COBRA coverage for those members who do not comply with the requirements outlined below;
c. Moda Health will not provide COBRA coverage if the COBRA Administrator fails to provide the required COBRA notices within the statutory time periods, or if the COBRA Administrator otherwise fails to comply with any of the requirements outlined below; and
d. Moda Health will not provide a disability extension if the COBRA Administrator fails to notify Moda Health within 60 days of its receipt of a disability extension notice from a qualified beneficiary.

For purposes of section 13.2, COBRA Administrator means either the Group or a third party administrator delegated by the Group to handle COBRA administration.

13.2.2 Qualifying Events

Subscriber. A subscriber may elect continuation coverage if coverage is lost because of termination of employment (other than termination for gross misconduct, which may include misrepresenting immigration status to obtain employment]), or a reduction in hours.

Spouse. The spouse of a subscriber has the right to continuation coverage if coverage is lost for any of the following qualifying events:

a. Death of the subscriber
b. Termination of the subscriber's employment (for reasons other than gross misconduct) or reduction in the subscriber's hours of employment with the Group
c. Divorce or legal separation from the subscriber
d. The subscriber becomes entitled to Medicare

(Also, if a subscriber eliminates coverage for his or her spouse in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the later divorce or legal separation will be considered a qualifying event even though the ex-spouse lost coverage earlier. If the ex-spouse notifies the COBRA Administrator within 60 days of the later divorce or legal separation and can establish that the coverage was eliminated earlier in anticipation of the divorce or legal separation, then COBRA coverage may be available for the period after the divorce or legal separation.)

Children. A child of a subscriber has the right to continuation coverage if coverage is lost for any of the following qualifying events:

a. Death of the subscriber
b. Termination of the subscriber's employment (for reasons other than gross misconduct) or reduction in a subscriber's hours of employment with the Group
c. Parents' divorce or legal separation
d. The subscriber becomes entitled to Medicare
e. The child ceases to be a "child " under the Plan

Domestic Partners. A domestic partner, who at the time of the qualifying event was covered under the Plan, can elect COBRA continuation coverage. Under the Plan, the domestic partner would have the same rights to COBRA continuation coverage as a spouse does, unless otherwise stated. Where this COBRA section refers to divorce or legal separation, termination of domestic partnership would apply for domestic partners.

Retirees. If the Plan provides retiree coverage and the subscriber's former employer files a chapter 11 bankruptcy proceeding, this may be a qualifying event for the retiree who loses coverage as a result, and for his or her covered dependents.

13.2.3 Other Coverage

The right to elect continuation coverage shall be available to persons who are entitled to Medicare or covered under another group health plan at the time of the election.

13.2.4 Notice and Election Requirements

Qualifying Event Notice. A dependent member's coverage terminates as of the last day of the month in which a divorce or legal separation occurs (spouse's coverage is lost) or a child loses dependent status under the Plan (child loses coverage). Under COBRA, the subscriber or a family member has the responsibility to notify the COBRA Administrator if one of these events

occurs by mailing or hand-delivering a written notice to the COBRA Administrator. The notice must include the following: 1) the name of the Group; 2) the name and social security number of the affected members; 3) the event (e.g. divorce): and 4) the date the event occurred. Notice must be given no later than 60 days after the loss of coverage under the Plan. If notice of the event is not given on time, continuation coverage will not be available.

Election Notice. Members will be notified of their right to continuation coverage within 14 days after the COBRA Administrator receives a timely qualifying event notice.

Otherwise, members will be notified by the COBRA Administrator of the right to elect COBRA continuation coverage within 44 days of any of the following events that result in a loss of coverage: the subscriber's termination of employment (other than for gross misconduct), reduction in hours, death of the subscriber, or the subscriber's becoming entitled to Medicare, or the Group files for Chapter 11 reorganization.

Election. A member must elect continuation coverage within 60 days after plan coverage ends, or, if later, 60 days after the COBRA Administrator sends notice of the right to elect continuation coverage to the members. If continuation coverage is not elected, group health insurance coverage will end.

A subscriber or the spouse may elect continuation coverage for eligible family members. However, each family member has an independent right to elect COBRA coverage. This means that a spouse or child may elect continuation coverage even if the subscriber does not.

If COBRA is elected, the Group will provide the same coverage as is available to similarly situated members under the Plan.

13.2.5 COBRA Premiums

Those eligible for continuation coverage do not have to show that they are insurable. However, they are responsible for all premiums for continuation coverage. The first payment for continuation coverage is due within 45 days after a member provides notice of electing coverage (this is the date the election notice is postmarked, if mailed, or the date the election notice is received by the COBRA Administrator, if hand-delivered). This payment must include the amount necessary to cover all months that have elapsed between the date regular coverage ended and the payment date. Subsequent payments are due on the first day of the month; however, there will be a grace period of 30 days to pay the premiums. Moda Health will not send a bill for any payments due. The member is responsible for paying the applicable premiums, in good funds, when due, otherwise continuation coverage will end and may not be reinstated. The premium rate may include a 2% add-on to cover administrative expenses.

13.2.6 Length of Continuation Coverage

18-Month Continuation Period. In the case of a loss of coverage due to end of employment or a reduction of hours of employment, coverage generally may be continued for up to a total of 18 months.

36-Month Continuation Period. In the case of losses of coverage due to a subscriber's death, divorce or legal separation, or a child ceasing to be a dependent under the terms of the Plan, coverage under the Plan may be continued for up to a total of 36 months.

When the qualifying event is the end of employment or reduction of the subscriber's hours of employment, and the subscriber became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA coverage under the Plan for members other than the subscriber who lose coverage as a result of the qualifying event can last up to 36 months after the date of Medicare entitlement. This COBRA coverage period is available only if the subscriber becomes entitled to Medicare within 18 months ***before*** the termination or reduction of hours.

Extended Period. In the case of loss of coverage due to the bankruptcy of the Group, coverage for the retired subscriber may be continued up to his or her death; coverage for each dependent may be continued up to the dependent's death or 36 months after the retired subscriber's death, whichever is earlier.

13.2.7 Extending the Length of COBRA Coverage

If COBRA is elected, an extension of the maximum period of coverage may be available if a member is disabled or a second qualifying event occurs. The COBRA Administrator must be notified of a disability or a second qualifying event in order to extend the period of COBRA coverage. If the member fails to provide notice of a disability or second qualifying event, they will lose the right to extend the period of COBRA coverage.

Disability. If any of the members is determined by the Social Security Administration to be disabled, the maximum COBRA coverage period that results from a subscriber's termination of employment or reduction of hours may be extended to a total of up to 29 months. The disability must have started at some time before the 61st day after the subscriber's termination of employment or reduction of hours and must last at least until the end of the period of COBRA coverage that would be available without the disability extension (generally 18 months). Each member who has elected COBRA coverage will be entitled to the disability extension if one of them qualifies.

The disability extension is available only if the COBRA Administrator is notified in writing of the Social Security Administration's determination of disability within 60 days after the latest of:

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

A member must provide the COBRA Administrator a copy of the Social Security Administration's determination within the 18-month period following the subscriber's termination of employment or reduction of hours, and not later than 60 days after the Social Security Administration's determination was made. If the notice is not provided within this timeframe, then there will be no disability extension of COBRA coverage. The premiums for COBRA coverage may increase after the 18th month of coverage to 150% of the premiums.

If determined by the Social Security Administration to no longer be disabled, the member must notify the COBRA Administrator of that fact within 30 days after the Social Security Administration's determination.

Second Qualifying Event. An extension of coverage will be available to spouses and children who are receiving COBRA coverage if a second qualifying event occurs during the 18 months (or, in the case of a disability extension, the 29 months) following the subscriber's termination

of employment or reduction of hours. The maximum amount of COBRA coverage available when a second qualifying event occurs is 36 months from the date of the first qualifying event. Such second qualifying events may include the death of a subscriber, divorce or legal separation from the subscriber, or a child's ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the member to lose coverage under the Plan if the first qualifying event had not occurred. (This extension is not available under the Plan when a subscriber becomes entitled to Medicare after his or her termination of employment or reduction of hours.).

This extension due to a second qualifying event is available only if the COBRA Administrator is notified in writing of the second qualifying event within 60 days after the date of the second qualifying event. If this notice is not provided to the COBRA Administrator during the 60-day notice period, then there will be no extension of COBRA coverage due to a second qualifying event.

Note: Longer continuation coverage may be available under Oregon Law for a subscriber's spouse or domestic partner age 55 and older who loses coverage due to the subscriber's death, or due to legal separation or dissolution of marriage or domestic partnership (see section 13.1).

13.2.8 Newborn or Adopted Child

If, during continuation coverage, a child is born to or placed for adoption with the subscriber, the child is considered an eligible member. The subscriber may elect continuation coverage for the child provided the child satisfies the otherwise applicable plan eligibility requirements (for example, age). The subscriber or a family member must notify the COBRA Administrator within 31 days of the birth or placement to obtain continuation coverage. If the subscriber or family member fails to notify the COBRA Administrator in a timely fashion, the child will not be eligible for continuation coverage.

13.2.9 Special Enrollment and Open Enrollment

Members under continuation coverage have the same rights as similarly situated members who are not enrolled in COBRA. A member may add children, spouses or domestic partners as covered dependents in accordance with the Plan's eligibility and enrollment rules, including HIPAA special enrollment. If non-COBRA members can change plans at open enrollment, COBRA members may also change plans at open enrollment.

13.2.10 When Continuation Coverage Ends

COBRA coverage will automatically terminate before the end of the maximum period if:

a. Any required premiums are not paid in full on time
b. A member becomes covered under another group health plan
c. A member becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing COBRA. (However, if the qualifying event is the Group's bankruptcy, the member will not lose COBRA because of entitlement to Medicare benefits)
d. The Group ceases to provide any group health plan for its employees
e. During a disability extension period (see section 13.2.7), the disabled member is determined by the Social Security Administration to be no longer disabled (COBRA coverage for all members, not just the disabled member, will end).

COBRA coverage may also be terminated for any reason the Plan would terminate coverage of a member not receiving COBRA coverage (such as fraud).

Questions about COBRA should be directed to the COBRA Administrator. The COBRA Administrator should be informed of any address changes.

13.3 STRIKE OR LOCKOUT

If employed under a collective bargaining agreement and involved in a work stoppage because of a strike or lockout, a subscriber may continue coverage for up to 6 months. The subscriber must pay the full premiums, including any part usually paid by the Group, directly to the union or trust, and the union or trust must continue to pay Moda Health the premiums when due.

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

a. Fewer than 75% of those normally enrolled choose to continue their coverage
b. A subscriber accepts full-time employment with another employer
c. A subscriber otherwise loses eligibility under the Plan

SECTION 14. 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 insurance plans.

14.1 What are a member's 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 handbook.
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 the 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 handbook to make sure they understand the Plan. Members are advised to call Customer Service with any questions.
b. Select a PCP for those plans that require it
c. To the extent required by the Plan, seek medical services only from their PCP
d. Obtain approval from their PCP before going to a specialist
e. Treat all providers and their staff with courtesy and respect.
f. Provide all the information needed for their provider to provide good healthcare.
g. Participate in making decisions about their medical care and forming a treatment plan.
h. Follow instructions for care they have agreed to with their provider.
i. Use urgent and emergency services appropriately.
j. Present their medical identification card when seeking medical care.
k. Notify providers of any other insurance policies that may provide coverage.
l. Reimburse Moda Health from any third party payments they may receive.

m. Keep appointments and be on time. If this is not possible, members must call ahead to let the provider know they will be late or cannot keep the appointment.
n. Seek regular health checkups and preventive services.
o. Provide adequate information to the Plan 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.

14.2 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.

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

It is the responsibility of the Group to notify members of benefit changes or termination of coverage. If the policy terminates and the Group does not replace the coverage with another group policy, the Group is required by law to inform its members in writing of the termination.

14.4 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 (P.O. Box 40384, Portland, Oregon 97240). Complete information in section 10.2.

A member may also contact the Oregon Insurance Division:

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

14.5 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 under the Plan. 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.

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

Moda Health protects members' 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

14.7 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 its services.

Moda Health has formed advisory committees, including the Group Advisory Committee for employers, and 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 at:

601 S.W. Second Avenue
Portland, Oregon 97204
www.modahealth.com/pebb

14.8 How can non-English speaking members get information about the Plan?

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

14.9 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.

14.10 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
P.O. 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

14.11 What is provider risk sharing?

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

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

P.O. Box 40384
Portland, OR 97204

modahealth.com