



Oregon Group Medical Plan

Public Employees' Benefit Board
Coordinated Care Model Plan
Synergy Part-Time +100

Effective Date: January 1, 2019
Group Number: 10002802



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



ModaORLGASObk 1-1-2019 (PEBB Synergy Part time +100)

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SECTION 1. WELCOME

This handbook describes the main features of the Group's medical plan (the Plan), but does not waive any of the conditions of the Plan as set out in the Plan Document.

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

Members may direct questions to one of the numbers listed in Section 2 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.

The group may change or replace this handbook at any time 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 agreement with Moda Health. This handbook may not contain every plan provision.

SECTION 2. MEMBER RESOURCES

2.1 CONTACT INFORMATION

Moda Health Website (log in to myModa)

www.modahealth.com/pebb

Includes many helpful features, such as:

- Find Care (use to find an in-network provider)
 - Prescription price check tool and formulary (medication cost estimates and benefit tiers)
 - Prior authorization lists (services and supplies that may require authorization)
- www.modahealth.com/medical/referrals

Medical Customer Service Department

844-776-1593

En Español 888-786-7461

Behavioral Health Customer Service Department

800-799-9391

Disease Management and Health Coaching

800-592-8283

Pharmacy Customer Service Department

844-776-1594

Telecommunications Relay Service for the hearing impaired

711

Moda Health

P.O. Box 40384

Portland, Oregon 97240

Public Employee's Benefit Board (PEBB)

503-373-1102

2.2 MEMBERSHIP CARD

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

2.3 NETWORKS

See Network Information (Section 5) for more detail about how networks work.

Medical network

Synergy

Pharmacy network

Northwest Prescription Drug Consortium

Travel network

First Health Network

2.4 CARE COORDINATION

2.4.1 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.

2.4.2 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:

- a. Explain and maximize available benefits
- b. Communicate with providers
- c. Work with the facility case managers to coordinate discharge plans
- d. Contact members at home to confirm and support the provider's treatment plan
- e. 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:

- a. Member name and ID number (this can be found on the member's Moda Health ID card)
- b. Contact name and number
- c. 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.

2.4.3 Disease Management

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

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

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

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.

2.4.4 Behavioral Health

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

2.4.5 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:

2.4.5.1 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>

2.4.5.2 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/>.

2.4.5.3 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.

2.4.5.4 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.

2.5 OTHER RESOURCES

Additional member resources providing general information about the Plan can be found in Section 11, Section 13 and Section 14.

SECTION 3. SCHEDULE OF BENEFITS

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

“Cost sharing” is the amount members pay. See Section 4 for more information, including an explanation of deductible, out-of-pocket maximum, and maximum cost share. For services provided out-of-network, members may also be responsible for any amount in excess of the maximum plan allowance.

	<u>In-Network Benefits</u>	<u>Out-of-Network Benefits</u>
Medical:		
Annual Medical Deductible per Member	\$600	\$1,100
Maximum Annual Medical Deductible per Family	\$1,800	\$3,300
Annual Medical Out-of-Pocket Maximum per Member	\$2,500	\$6,000
Annual Medical Out-of-Pocket Maximum per Family	\$7,500	\$18,000
Pharmacy:		
Annual Pharmacy Deductible per Member	\$50	
Maximum Annual Pharmacy Deductible per Family	\$150	
Annual Pharmacy Out-of-Pocket Maximum per Member	\$1,000	
Annual Pharmacy Out-of-Pocket Maximum per Family	\$3,000	
Maximum Annual Cost Sharing per Member (Medical & pharmacy)	\$6,850	N/A
Maximum Annual Cost Sharing per Family (Medical & pharmacy)	\$13,700	N/A

Services	Cost Sharing (Deductible applies unless noted differently)		Section in Handbook & Details
	In-network	Out-of-network	
Urgent & Emergency Care			
Ambulance Transportation	\$75 per trip	\$75 per trip	Section 7.3.1
Emergency Room Facility	\$150 per visit*	\$150 per visit* In-network deductible and maximum cost sharing apply.	Section 7.3 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
Urgent Care Office Visit	\$30 per visit	\$30 per visit	Section 7.3.6

Services	Cost Sharing (Deductible applies unless noted differently)		Section in Handbook & Details
	In-network	Out-of-network	
Preventive Services			
Preventive Healthcare			Section 7.4
Services as required under the Affordable Care Act, including the following:			Section 7.4
Colonoscopy	No cost sharing	50%	Section 7.4.1 One per 10 years, age 50+. Related charges included
Immunizations	No cost sharing	50%	Section 7.4.3
Newborn Hearing Screening	No cost sharing	50%	Section 7.4.4
Vision Screening	No cost sharing	50%	Section 7.4.4 Age 3 to 5
Preventive Health Exams (by primary care provider only)	No cost sharing	50%	Section 7.4.5 6 visits in first year of life 7 exams from age 1 to 4 One per year, age 5+
Women's Annual Exam & Pap Test	No cost sharing	50%	Section 7.4.7 One per year
Routine Mammogram	No cost sharing	50%	Section 7.4.7 One per year, age 40+
Other preventive services Including:			
Diagnostic X-ray & Lab	No cost sharing	50%	Section 7.4.5
Prostate Rectal Exam	No cost sharing	50%	Section 7.4.6 One per year, age 50+
Prostate Specific Antigen (PSA) Test	No cost sharing	50%	Section 7.4.6 One per year, age 50+
Tobacco Cessation Treatment			Section 7.4.8
Consultation	No cost sharing	Not covered	
Supplies	No cost sharing	15%	
Ambulatory Services			
Acupuncture	\$40 per visit*	50%**	Section 7.5.1 \$1,000 annual maximum includes spinal manipulation
Anticancer Medication			Section 7.5.2
Injectable Medications	\$40 per visit	50%	
Self-administered Generic and Brand medications	\$40, no deductible	50%	30-day supply. Specialty medications must be from the exclusive pharmacy provider

Services	Cost Sharing (Deductible applies unless noted differently)		Section in Handbook & Details
	In-network	Out-of-network	
Applied Behavior Analysis			Section 7.5.3
Office Visits	\$40 per visit, no deductible	50%	
Other Services	\$40 per visit, no deductible	50%	
Biofeedback	\$40 per visit	50%	Section 7.5.4
Chemical Dependency Services	No cost sharing	50%	Section 7.5.5
Dental Injury	\$40 per procedure	50%	Section 7.5.9
Diabetes Services	No cost sharing	50%	Section 7.5.10 Once, following diagnosis
Diabetic Supplies and Insulin	No cost sharing	No cost sharing	Section 7.9.3 Covered under the pharmacy benefit
Diabetic Pumps and Meters	20%	50%	Section 7.8.1 Covered as a Durable Medical Equipment (DME) supply
Diagnostic Procedures, including x-ray and lab			Section 7.5.11
At Quest Labs	No cost sharing	N/A	
All other providers	20%	50%	
Imaging Procedures	\$100* per service, then 20%	\$100* per service, then 50%	Section 7.5.11 Copay does not apply to services related to cancer diagnosis and treatment
Sleep Studies	\$100* per procedure, then 20%	\$100*, then 50%	
Infusion Therapy Home or Outpatient	\$40 per visit	50%	Section 7.5.15 Some medications require use of authorized provider to be eligible for coverage. Outpatient hospital setting not covered for some medications.

Services	Cost Sharing (Deductible applies unless noted differently)		Section in Handbook & Details
	In-network	Out-of-network	
Kidney Dialysis	\$40 per service	50%	Section 7.5.16
Mental Health Services	\$40 per visit, no deductible	50%	Section 7.5.19
Mental Health Facility	\$40 per service, no deductible	50%	
Nutritional Therapy	No cost sharing for first 2 visits, then \$40 per visit, no deductible	50%	Section 7.5.20 Prior authorization required after 5 visits
Office Visits to Primary Care Providers	\$40 per visit (First 4 visits, no deductible)	50%	Section 7.5.21
Specialist Visits	\$40 per visit	50%	Section 7.5.21
Office Visits to Naturopaths, Chiropractors and Acupuncturists	\$40 per visit*	50%**	Section 7.5.21
Office Visits for Chronic Conditions	No cost sharing	50%	Section 7.5.21 Chronic conditions: asthma, diabetes, heart conditions
E-Visits	No cost sharing	Not covered	Section 7.5.12
Rehabilitation & Habilitation (Physical, occupational and speech therapy)	\$40 per visit	50%	Section 7.5.23 60 sessions per year, except as required for mental health parity. Habilitation only covered for mental health conditions
Cardiac Rehabilitation	\$40 per service	50%	Section 7.5.23
Spinal Manipulation	\$40 per visit*	50%**	Section 7.5.24 \$1,000 annual maximum includes acupuncture
Surgery Procedures	\$40 per service	50%	Section 7.5.25
Outpatient Surgery Facility	\$40 per service	\$100* per service, then 50%	
Temporomandibular Joint Syndrome	\$40 per service	Not covered	Section 7.5.26 Related physical therapy visits up to 20 visits per year
Therapeutic Injections	\$40 per service	50%	Section 7.5.27
Allergy Shots, Serums	\$15 per service	50%	Section 7.5.27
Therapeutic X-ray	\$40 per service	50%	Section 7.5.28

Services	Cost Sharing (Deductible applies unless noted differently)		Section in Handbook & Details
	In-network	Out-of-network	
Additional Cost Tier			
Bunionectomy	\$100 per service*	\$100*, then 50%	Section 4.1 Does not include services related to cancer diagnosis or treatment for traumatic injury
Hammertoe surgery	\$100 per service*	\$100*, then 50%	
Knee viscosupplementation	\$100 per service*	\$100*, then 50%	
Morton's neuroma	\$100 per service*	\$100*, then 50%	
Spinal injections for pain	\$100 per service*	\$100*, then 50%	
Upper gastrointestinal endoscopy	\$100 per service*	\$100*, then 50%	
Knee arthroscopy	\$500 per service*	\$500*, then 50%	
Knee, hip replacement	\$500 per service*	\$500*, then 50%	
Knee, hip resurfacing	\$500 per service*	\$500*, then 50%	
Shoulder arthroscopy	\$500 per service*	\$500*, then 50%	
Sinus surgery	\$500 per service*	\$500*, then 50%	
Spine procedures	\$500 per service*	\$500*, then 50%	
Bariatric surgery	\$500 per service*	Not covered	
Inpatient & Residential Facility Care			
Bariatric Surgery Facility	\$500 per admission	Not covered	Section 7.6.2
Chemical Dependency Detoxification	No cost sharing	50%	Section 7.6.8
Hospital Physician Visits	No cost sharing	50%	Section 7.6.5
Inpatient Care	\$500 per admission	\$500* per admission then 50%	Section 7.6.4
Observation Care	\$500 per admission	\$500* per admission then 50%	Section 7.6.4
Rehabilitation & Habilitation (Physical, occupational and speech therapy)	\$500 per admission	50%	Section 7.6.7 30 days per year, except as required for mental health parity. May be eligible for up to 60 days for head or spinal cord injury, or for treatment of a stroke. Habilitation only covered for mental health conditions
Residential Mental Health Treatment Program	\$500 per admission	50%	Section 7.6.8
Residential Chemical Dependency Treatment Program	No cost sharing	50%	Section 7.6.8
Skilled Nursing Facility Care	\$500 per admission	50%	Section 7.6.9 180 days per year

Services	Cost Sharing (Deductible applies unless noted differently)		Section in Handbook & Details
	In-network	Out-of-network	
Surgery	No cost sharing	50%	Section 7.6.10
Transplants			Section 7.6.13
Center of Excellence Facilities			
Facility charges	\$500 per admission	N/A	
Professional charges	\$40 per visit	N/A	
Maternity Services			
Breastfeeding			Section 7.7.1
Support and Counseling	No cost sharing	50%	
Supplies	No cost sharing	No cost sharing	
Infertility services	50%**	50%**	Section 7.7.6
Maternity			Section 7.7
Facility Charges	\$500 per admission	\$500* per admission then 50%	Section 7.7.5
Prenatal Visits	No cost sharing	50%	
Professional Delivery and Postnatal	No cost sharing	50%	
Newborn Nursery Care	First visit covered at no cost sharing, then \$500 per admission	\$500* per admission then 50%	Section 7.7.5
Other Services			
Durable Medical Equipment	20%	50%	Section 7.8.1
Supplies and Appliances	20%	50%	Section 7.8.1
Disposable Supplies (provided in a professional provider's office)	20%	50%	Section 7.8.1
Hearing Aids and Related Services	10%**	10%** (in-network deductible applies)	Section 7.8.2 Once every 36 months
Hearing Exams	\$40 per visit*	50%**	Section 7.8.2 Once every year
Home Healthcare	\$40 per visit	50%	Section 7.8.3 180 visits per year
Hospice Care			Section 7.8.4
Home Care	No cost sharing	No cost sharing	
Inpatient Care	No cost sharing	No cost sharing	
Respite Care	No cost sharing	No cost sharing	

Services	Cost Sharing (Deductible applies unless noted differently)		Section in Handbook & Details
	In-network	Out-of-network	
Pharmacy			
Prescription Medications			Section 7.9
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	\$20	\$20	
Brand Tier	\$50	\$50	
Mail Order Pharmacy			90-day supply per prescription
Value Tier	No cost sharing	N/A	
Generic Tier	\$50	N/A	
Brand Tier	\$125	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	\$40	\$40	
Specialty Pharmacy	\$40	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.

SECTION 4. PAYMENT & COST SHARING

4.1 ADDITIONAL COST TIER

When certain surgical procedures with less invasive alternatives are performed, they are subject to a copayment in addition to the standard cost sharing. Additional cost tier procedures include the following:

\$100 cost tier:

- a. Bunionectomy
- b. Hammertoe surgery
- c. Knee viscosupplementation
- d. Morton's Neuroma
- e. Spinal injections for pain
- f. Uppergastrointestinal endoscopy

\$500 cost tier:

- a. Knee arthroscopy
- b. Knee, hip replacement
- c. Knee, hip resurfacing
- d. Shoulder arthroscopy
- e. Sinus surgery
- f. Spine procedures
- g. Bariatric surgery

Visit myModa or contact Customer Service for more information regarding the additional cost tier. Also see sections 7.5.25, 7.5.11 and 7.6.10 for imaging and surgery benefits generally.

4.2 DEDUCTIBLES

The Plan has separate annual medical and pharmacy deductibles. The deductible amounts are shown in Section 3 and are the amount of covered expenses that are paid by members before benefits are payable by the Plan. That means the member pays the full cost of services that are subject to the deductible until he or she has spent the deductible amount. Then the Plan begins sharing costs with the member.

All amounts for medical services accumulate separately. The deductible is lower when using in-network providers. After the deductible has been satisfied, benefits will be paid according to Section 3. When a per member deductible is met, benefits for that member will be paid according to Section 3. 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 3.), which is calculated separately from any other deductible that may apply to the Plan. Covered prescription drug expenses, whether received in-network or out-of-network, accumulate toward the pharmacy deductible. After the deductible has been satisfied, benefits will be paid according to Section 3. When a per member deductible is met, benefits for that member will be paid according to Section 3. If coverage is for more than one member, the per member deductible applies only until the total family deductible is reached.

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 health benefit plan of the Group, any deductible amount satisfied under the prior plan 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.

4.3 ANNUAL MAXIMUM OUT-OF-POCKET

The Plan has a per member and per family annual out-of-pocket maximum for in-network and out-of-network medical expenses. After the annual per member or per family out-of-pocket maximum is met, the Plan will pay 100% of covered services and supplies 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. 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 in-network and out-of-network out-of-pocket maximums accumulate separately and are not combined.

The Plan has separate per member and per family out-of-pocket maximums for pharmacy medication expenses (as shown in Section 3, 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 pharmacy 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

4.4 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). Except as noted below, members' cost sharing towards deductibles, copayments and coinsurance for essential health benefits performed by an

in-network provider accumulates toward the annual maximum cost share. If coverage is for more than one member, the per member maximum applies only until the total family maximum cost share is reached. After the per member or per family annual maximum cost share is met, the Plan will pay 100% of essential health benefits for the remainder of the year. For out-of-network providers, the Plan will continue to pay as shown in Section 3.

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 in-network out-of-pocket maximums also applies to the maximum cost share.

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

Members are responsible for the following costs (they do not accrue toward the maximum cost share and members must pay for them even after the maximum cost share is met):

- a. Services in excess of any maximum
- b. Services performed by out-of-network providers
- c. Spinal manipulation and acupuncture services
- d. Expenses incurred due to brand substitution
- e. Fees in excess of maximum plan allowance
- f. Other services that do not qualify as essential health benefits
- g. Premiums and penalties
- h. Disallowed charges

4.5 PAYMENT

Expenses allowed by the Plan are based upon the maximum plan allowance (see Section 14), which is a contracted fee for in-network providers. For out-of-network providers the maximum plan allowance is an amount established, reviewed, and updated by a national database. Depending upon the Plan provisions, cost sharing may apply.

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

4.6 EXTRA-CONTRACTUAL SERVICES

Extra-contractual services are services or supplies that are not otherwise covered, 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, extra-contractual services will be covered when agreed upon by a member and his or her professional provider and Moda Health. Any party can provide notification in writing and terminate such services.

The fact that the Plan has paid benefits for extra contractual 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 extra-contractual services for the same member. All amounts paid for extra-contractual services under this provision shall be included in computing any benefits, limitations or cost sharing under the Plan.

SECTION 5. NETWORK INFORMATION

In-network benefits apply to services delivered by medical home providers or other in-network providers. Out-of-network benefits apply to services delivered by out-of-network providers. By using a medical home provider, members will receive quality healthcare and will have a higher level of benefits.

Remember to ask providers to send any lab work or x-rays to an in-network facility for the highest benefits. See section 5.2 for more information. 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).

5.1 GENERAL NETWORK INFORMATION

5.1.1 Primary Network; Primary Service Area

All members 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.

Members should ask if their provider (both professional provider and facility) is participating with the specific network listed below. Do not ask if the provider accepts Moda. There are many Moda Health networks. A provider may accept Moda insurance, but not be participating with the network for the Plan. Members may contact Customer Service for help finding an in-network provider.

Networks

Medical network is Synergy Network, with providers in Benton, Clackamas, Clatsop, Columbia, Coos, Crook, Curry, Deschutes, Douglas, Hood River, Jackson, Jefferson, Josephine, Klamath, Lane, Lincoln, Linn, Marion, Multnomah, Polk, Tillamook, Wasco, Washington and Yamhill counties.

Pharmacy network is Northwest Prescription Drug Consortium

5.1.2 Coverage Outside the Service Area for Children

Enrolled children residing outside the primary service area may receive in-network benefits by using a travel network provider as described in section 5.1.3. If a travel network provider is not available, plan benefits will be extended to such children as if the care were rendered by in-network providers, subject to the following limitations:

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

In-network benefits are not available to a child residing outside the service area for the purpose of receiving treatment or benefits.

When an enrolled child moves outside the service area, the subscriber must contact Customer Service and his or her employer to update the address with Moda Health. The enrolled child will be eligible for out-of-area coverage the first day of the month following the date the address is updated in the Moda Health system.

5.1.3 Travel Network

Members traveling outside of the primary service area may receive in-network benefits by using a travel network provider for urgent or emergency services. The in-network benefit level only applies to a travel network provider if members are outside the primary service area and the travel is not for purposes of receiving treatment or benefits.

Travel Network

First Health Network

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

5.1.4 Out-of-Network Care

When members choose healthcare providers that are not in-network, the benefit from the Plan is lower, at the out-of-network level described in Section 3. In most cases the member must pay the provider all charges at the time of treatment, and then file a claim to be reimbursed the out-of-network benefit. If the provider's charges are in excess of the maximum plan allowance, the member may be responsible for paying those excess charges.

When receiving care at an in-network facility, ask to have ancillary services (such as diagnostic testing, anesthesia, surgical assistants) performed by in-network providers to ensure the highest benefit level. When the member is at an in-network facility and is not able to choose the provider, in-network cost sharing will apply to services by out-of-network providers, and an Oregon-licensed provider cannot balance bill the member except when permitted by law.

5.1.5 Care after Normal Office Hours

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

5.2 COORDINATED CARE MODEL

The medical networks selected by the Group provides a coordinated system of healthcare delivery that is designed to promote appropriate healthcare decisions by all members. More information on the networks is in section 5.1.

5.2.1 Medical Homes

The Plan provides the highest benefit level for services provided by medical home providers. A medical home PCP is a professional provider who specializes in family practice, general practice, internal medicine or pediatrics. At enrollment, members are required to select a primary care provider from the medical homes (section 5.2.2).

Medical home providers will coordinate medical care for members and arrange for care from specialists and prior authorizations. 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 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.

5.2.2 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. Enrolled children may choose a pediatrician and female members may designate a women's healthcare provider as the medical home PCP. Members may find a medical home provider online by using Find Care 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 utilize their myModa account to indicate their selected medical home for each covered family member
- b. Phone: Contact Customer Service
- c. Mail: Download and complete the Medical Home selection form located on myModa

Mail: Moda Health
Attn: PEBB Membership Accounting
PO Box 40384
Portland, OR 97240

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.

5.2.3 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.

The medical home PCP is responsible for providing and/or coordinating all healthcare needs for the member. 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.

5.2.4 Other In-Network Primary Provider Care

Members may use any in-network provider, however, care should be coordinated by the medical home PCP. There are prior authorization requirements for certain services (see Section 6). A member may see an in-network women's healthcare provider instead of the medical home PCP for preventive women's health exams and other gynecological care and for pregnancy care.

5.2.5 Out-of-Network Provider Care

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 may be responsible for the copayment or coinsurance and any amount in excess of the maximum plan allowance when using an out-of-network provider.

5.3 USING FIND CARE

To search for in-network providers, members can log in to their myModa account at modahealth.com and click on Find Care near the top right of the page.

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

5.3.1 Medical Home Providers

Find a Medical Home provider:

- a. Choose the "Medical Home Clinics & Medical Groups" or "Medical Home Providers & Doctors" option under the Type drop down menu
- b. Enter ZIP code and Search

The search will bring up a list of Medical Home providers. These providers will have a picture of a house in a circle (the Medical Home badge icon) next to their contact information.

SECTION 6. PRIOR AUTHORIZATION

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

When a professional provider suggests a type of service requiring authorization (see section 6.1.1), the member should ask the provider to contact Moda Health for prior authorization. Authorization for emergency hospital admissions must be obtained by calling Moda Health within 48 hours of the emergency hospital admission (or as soon as reasonably possible). The hospital, professional provider and member are notified of the outcome of the authorization process by letter. Prior authorization does not guarantee coverage. When a service is otherwise excluded from benefits, charges will be denied.

6.1 PRIOR AUTHORIZATION REQUIREMENTS

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

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

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

Prior authorization is not required for an emergency admission.

Authorization may be considered after services are received for medications purchased at the pharmacy.

6.1.1 Services Requiring Prior Authorization

Many services within the following categories may require prior authorization:

- a. Inpatient services and residential programs
- b. Outpatient services
- c. Rehabilitation (physical, occupational, speech therapy)
- d. Imaging services
- e. Infusion therapy
- f. Medications

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

contacting Customer Service. For mental health or chemical dependency services, contact Behavioral Health Customer Service.

6.1.2 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.

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. The details of the different types of benefits and the conditions, limitations and exclusions are described in the sections that follow. An explanation of important terms is found in Section 14.

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

Many services 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 6).

7.1 MEMBER’S RESPONSIBILITY IN THE PLAN

Members are responsible for:

- a. Selecting a medical home primary care physician (PCP) from within the network
- b. Actively consulting with the medical home PCP to ensure that all care is being provided in-network. Members may be responsible for part or all of the charges for services provided out-of-network

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 paid his or her premiums for the current month on a timely basis

7.3 URGENT & EMERGENCY CARE

Care received outside of the United States is only covered for an urgent care or emergency medical condition. Emergency services will be reimbursed at the in-network benefit level. Members will need to pay for these services upfront and submit a claim to Moda Health for reimbursement (as described in section 10.1.4).

7.3.1 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. Out-of-network providers may bill members for charges in excess of the maximum plan allowance.

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

7.3.2 Emergency Room Care

Members are covered for treatment of emergency medical conditions (as defined in Section 14) worldwide. A member who believes he or she has a medical emergency should call 911 or seek care from the nearest appropriate provider.

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

All claims for emergency services (as defined in Section 14) will be paid at the in-network benefit level. Out-of-network providers may bill members for charges in excess of the maximum plan allowance. Using an in-network emergency room does not guarantee that all providers working in the emergency room and/or hospital are also in-network providers. Emergency care 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 7.3 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.

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

7.3.3 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 911. They should call the medical home PCP within 24 hours of the initial medical care, or as soon thereafter as possible.

7.3.4 Emergencies and Urgent Care Outside the Service Area

Members who are outside of the service area when a medical emergency occurs should seek medical attention from the nearest appropriate facility or call 911. 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 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 PCP has requested a prior authorization that has been approved by Moda Health, and the 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. Urgent care visits
- b. Care of chronic conditions, including diagnostic services
- c. Preventive Services
- d. Elective surgery and/or hospitalization
- e. Outpatient mental health services

7.3.5 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.

7.3.6 Urgent Care

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 is covered. The member must be actually examined by a professional provider.

7.4 PREVENTIVE SERVICES

As required under the Affordable Care Act (ACA), certain services will be covered at no cost to the member when performed by an in-network provider (see Section 3 for benefit level when services are provided out-of-network). Moda Health will use reasonable medical management techniques to determine coverage limitations where permitted by the ACA. This means that some alternatives in the services below may be subject to member cost sharing:

- a. Evidence-based services rated A or B by the United States Preventive Services Taskforce (www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/) and including women's preventive services as of January 1, 2017
- 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/) and including women's services as of January 1, 2017

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

Members may call Customer Service to verify if a preventive service is covered at no cost sharing or visit the Moda Health website for a list of preventive services covered at no cost sharing as required by the ACA. Other preventive services are subject to the applicable cost sharing when

not prohibited by federal law. Some frequently used preventive healthcare services covered by the Plan are:

7.4.1 Colorectal Cancer Screening.

The following services, including related charges, for members age 50 and over:

- a. One flexible sigmoidoscopy and pre-surgical exam or consultation every 5 years
- b. One colonoscopy, including polyp removal, and pre-surgical exam or consultation every 10 years
- c. One double contrast barium enema every 5 years
- d. One fecal DNA test every 3 years
- e. One fecal occult blood test every year

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

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

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

For members who are at high risk for colorectal cancer, including those with a family medical history of known genetic disorders that predispose them to a high lifetime risk of colorectal cancer (such as Lynch syndrome), a prior occurrence of colorectal cancer or adenomatous polyp, a personal history of inflammatory bowel disease, 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 criteria for the USPSTF A or B rated recommendation.

7.4.2 Contraception

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

7.4.3 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.

7.4.4 Pediatric Screenings

- a. Screening for hearing loss in newborn infants.
- b. Routine vision screening to detect amblyopia, strabismus and defects in visual acuity in children age 3 to 5

7.4.5 Preventive Health Exams

Covered according to the following schedule:

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

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

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

7.4.6 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.

7.4.7 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 instead of the medical home PCP for preventive women's health exams. This includes follow-up visits resulting from an exam covered under this provision. 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 PCP informed of the medical care being provided.

7.4.8 Tobacco Cessation

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

A tobacco cessation program can provide an overall treatment program that follows the United States Public Health Service guidelines for tobacco use cessation. Members may have more success with a coordinated program. Look for Moda Health's partner tobacco cessation program in myModa under the myHealth tab, or contact Customer Service.

7.5 OUTPATIENT SERVICES

Many outpatient services require prior authorization (see 6.1). All services must be medically necessary.

7.5.1 Acupuncture and Spinal Manipulation

Benefits are limited to an annual dollar maximum, which includes spinal manipulation (see section 7.5.24) and acupuncture. Other services, such as office visits or lab and diagnostic services are not covered under this benefit. They are paid under the Plan's standard benefit for the type of service provided.

7.5.2 Anticancer Medication

Prescribed anticancer medications, including oral, intravenous (IV) or injected medications, are covered. Most anticancer medications may require prior authorization and be subject to specific benefit limitations. Self-administered medications require delivery by a Moda-designated specialty pharmacy (see section 7.9.7). 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.

7.5.3 Applied Behavior Analysis

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

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

Coverage for applied behavior analysis does not include:

- a. Services provided by a family or household member
- b. Custodial or respite care, equine assisted therapy, creative arts therapy, wilderness or adventure camps, music therapy, neurofeedback, chelation or hyperbaric chamber
- c. Services provided under an individual education plan in accordance with the Individuals with Disabilities Education Act (20 USC 1400 et seq)
- d. Services provided by the Department of Human Services or Oregon Health Authority, other than employee benefit plans offered by the Department and the Authority

7.5.4 Biofeedback

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

7.5.5 Chemical Dependency Services

Services for assessment and treatment of chemical dependency in an outpatient treatment program that meets the definitions in the Plan (see Section 14) are covered.

7.5.6 Child Abuse Medical Assessment

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

7.5.7 Clinical Trials

Usual care costs for the care of a member who is enrolled in or participating in an approved clinical trial are covered. Usual care 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 same cost sharing that would apply if provided in the absence of a clinical trial.

Approved clinical trials are limited to those:

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

The Plan does not cover items or services:

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

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

7.5.8 Cochlear Implants

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

7.5.9 Dental Injury

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 performed within 12 months of the date of injury
- d. Treatment is medically necessary and is provided by a physician or dentist while the member is enrolled in the Plan
- e. Treatment is limited to that which will restore teeth to a functional state

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.

7.5.10 Diabetes Services

Insulin and diabetic supplies including insulin syringes, needles and lancets, and test strips are covered under the pharmacy benefit (section 7.9.3) with a valid prescription.

Covered medical services for diabetes screening and management include:

- a. Pumps and glucometers (covered under DME benefit (section 7.8.1))
- b. HbA1c lab test
- c. Checking for kidney disease
- d. Annual dilated eye exam or retinal imaging, including one performed by an optometrist or ophthalmologist
- e. 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
- f. Dietary or nutritional therapy
- g. Routine foot care when medically necessary

Telemedicine or telecare (section 7.8.6) in connection with covered treatment of diabetes can be delivered via audio, video conferencing, Voice over Internet Protocol, or transmission of telemetry. One of the participants must be a representative of an academic health center.

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.

7.5.11 Diagnostic Procedures

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

The Plan covers all standard imaging procedures related to treatment of a medical condition. Some advanced imaging services require prior authorization (see Section 6), including radiology (such as MR procedures (including MRI and MRA), CT, PET and nuclear medicine) and cardiac imaging.

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

7.5.12 Electronic Visits (E-Visits)

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

- a. The member has previously been treated in the medical home 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

Email 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.

7.5.13 Gender Identity Disorder/Gender Dysphoria Services

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)
 - i. Single stage or multiple stage reconstruction of the genitalia
- e. The following procedures are excluded, unless the medical necessity criteria are met:
 - i. Blepharoplasty
 - ii. Hair removal for surgical reconstruction (i.e. genital hair removal)
 - iii. Breast augmentation procedures
 - iv. Voice therapy/voice modification
 - v. Removal of redundant skin (i.e. Panniculectomy)

The following services are not medically necessary for all medical conditions and 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. Brow Lift
- f. Liposuction/abdominoplasty of the waist (body contouring)
- g. Reduction of thyroid chondroplasty
- h. Facial hair removal/hair transplantation
- i. Voice modification surgery (laryngoplasty or shortening of the vocal cords)
- j. Skin resurfacing used in feminization
- k. Chin implants/Cheek Implants
- l. Nose implants
- m. Lip reduction
- n. Collagen injections
- o. Reversal, revision, or removal of gender reassignment surgery

- p. Make up evaluation
- q. Legal expenses related to name change
- r. Travel and lodging expenses

7.5.14 Inborn Errors of Metabolism

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

7.5.15 Infusion Therapy

The Plan covers infusion therapy services and supplies when prior authorized and ordered by a professional provider as a part of an infusion therapy regimen. For some medications, authorization may be limited to preferred home infusion providers or provider office infusion only. When authorization is limited to preferred home infusion providers or provider office, infusion therapy administered at a hospital outpatient facility or other in-network provider may not be covered. See section 7.9.7 for self-administered infusion therapy.

Infusion therapy benefits are limited to the following:

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

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

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

7.5.16 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.

7.5.17 Maxillofacial Prosthetic Services

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

7.5.18 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. See section 7.5.15 for more information about infusion therapy and prior authorization requirements. Self-administered medications are not covered under this benefit (see section 7.9.7). See section 7.9 for pharmacy benefits.

7.5.19 Mental Health

The Plan covers medically necessary outpatient services including behavioral health case management and peer support, other than diagnostic testing, by a mental health provider. Intensive outpatient treatment requires prior authorization. See Section 14 for definitions. See section 7.5.11 for coverage of diagnostic services.

7.5.20 Nutritional Therapy

Nutritional therapy for eating disorders is covered when medically necessary. Authorization is required after the first 5 visits. Preventive nutritional therapy that may be required under the Affordable Care Act is covered under the preventive care benefit. Also see diabetes services (section 7.5.10) and inborn errors of metabolism (section 7.5.14).

7.5.21 Office or Home 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 surgery consultations. Ancillary services (such as lab tests) received in conjunction with the office visits are subject to the standard cost sharing.

7.5.22 Podiatry Services

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

7.5.23 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. They are necessary to restore or improve lost function caused by a medical condition.

Rehabilitative services are subject to an annual limit, which may be increased if rehabilitative services are required following acute head or spinal cord injury when the criteria for additional services are met. To receive this additional benefit, prior authorization must be obtained before the initial sessions have been exhausted. A session is one visit. No more than one session of each type of physical, occupational or speech therapy is covered in one day. Medically necessary outpatient services for mental health and chemical dependency are not subject to these limits.

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

7.5.24 Spinal Manipulation and Acupuncture

Benefits are limited to an annual dollar maximum, which includes spinal manipulation and acupuncture (see section 7.5.1). Other services, such as office visits, lab and diagnostic x-rays, and physical therapy services are not covered under this benefit. They are paid under the Plan's standard benefit for the type of service provided.

7.5.25 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. See sections 7.6.11 and 7.6.12 for more information about cosmetic and reconstructive surgery.

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

7.5.26 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.

7.5.27 Therapeutic Injections

Administrative services for therapeutic injections, such as allergy shots, are covered when given in a professional provider's office. When comparable results can be obtained safely with self-administered medications at home, the administrative services for therapeutic injections by the provider are not covered. Vitamin and mineral injections are not covered unless medically

necessary for treatment of a specific medical condition. Additional information is in sections 7.5.18 and 7.9.7.

7.5.28 Therapeutic Radiology

Covered expenses include:

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

7.6 INPATIENT & RESIDENTIAL FACILITY CARE

All facility care must be medically necessary in order to be covered.

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

Hospitalization must be directed by a physician and must be medically necessary. All inpatient and residential stays require prior authorization (see Section 6). Failure to obtain required prior authorization will result in denial of benefits.

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

7.6.1 Chemical Dependency Detoxification Program

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

7.6.2 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
 - i. Moda Health has arranged or contracted with to provide bariatric surgery and
 - ii. meets the Health Evidence Review Commission guidelines for facilities providing bariatric surgery

7.6.3 Diagnostic Procedures

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

The Plan covers all standard imaging procedures related to treatment of a medical condition. Some advanced imaging services require prior authorization (see Section 6), including radiology (such as MR procedures (including MRI and MRA), CT, PET and nuclear medicine) and cardiac imaging.

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

7.6.4 Hospital Benefits

Covered expenses for hospital care consist of the following:

- a. **Hospital room.** The actual daily charge
- b. **Isolation care.** When it is medically necessary to protect a member from contracting the illness of another person or to protect other patients from contracting the illness of a member
- c. **Intensive care unit.** Whether a unit in a particular hospital qualifies as an intensive care unit is determined using generally recognized standards
- d. **Facility charges.** For surgery performed in a hospital outpatient department
- e. **Other hospital services and supplies.** Those medically necessary for treatment and ordinarily furnished by a hospital

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.

7.6.5 Hospital Visits

A visit means the member is actually examined by a professional provider. Covered expenses include consultations with written reports, as well as second opinion consultations.

7.6.6 Pre-admission Testing

Medically necessary pre-admission testing is covered when ordered by the physician.

7.6.7 Rehabilitative Care

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

Covered rehabilitative 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 acute head or spinal cord injury, subject to medical necessity and prior authorization. Medically necessary services for mental health and chemical dependency are not subject to these limits.

Habilitative services are covered only for medically necessary treatment of a mental health condition.

7.6.8 Residential Mental Health & Chemical Dependency Treatment Programs

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

7.6.9 Skilled Nursing Facility Care

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

Covered skilled nursing facility days are subject to an annual limit.

Covered expenses are limited to the daily service rate, but no more than the amount that would be charged if the member were in a semi-private hospital room.

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

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

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

7.6.10 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

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.

7.6.11 Surgery, Cosmetic & Reconstructive

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 done to approximate a normal appearance.

Cosmetic surgery is not covered. All reconstructive procedures, including surgical, dental and orthodontic repair of congenital deformities, must be medically necessary and prior authorized

or benefits will not be paid. Reconstructive procedures that are partially cosmetic in nature may be covered if the procedure is medically necessary.

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 7.6.12.

7.6.12 Surgery, Reconstructive Following a Mastectomy

As used in this section (Women's Health and Cancer Rights Act), 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 Plan's terms and conditions, including the prior authorization and cost sharing provisions.

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

7.6.13 Transplants

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

Definitions
Center of Excellence means a facility and/or team of professional providers with which Moda Health has contracted and arranged to provide facility transplant services. Centers of Excellence have rigorous standards based on best practices, and have exceptional skills and expertise in managing patients with a specific condition.

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

Transplant means a procedure or series of procedures by which:

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

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.

- a. **Covered Benefits.** Benefits for transplants are limited as follows: Transplant procedures must be performed at a Center of Excellence. If a Center of Excellence cannot provide the necessary type of transplant, Moda Health will prior authorize services at an alternative transplant facility.
- b. Donor costs are covered as follows:
 - i. 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.
 - ii. If the donor is enrolled in the Plan and the recipient is not, the Plan will not pay any benefits toward donor costs.
 - iii. If the donor is not enrolled in the Plan, expenses that result from complications and unforeseen effects of the donation are not covered.
- c. Travel expenses for the recipient are subject to a \$5,000 combined maximum for transportation, food and lodging. Food and lodging is also subject to a \$150 daily limit.
- d. Professional provider transplant services are paid according to the benefits for professional providers.
- e. Immunosuppressive drugs provided during a hospital stay are paid as a medical supply. Outpatient oral and self-injectable prescription medications for transplant related services are paid under the Pharmacy Prescription benefit (section 7.9).
- f. The Plan will not pay for chemotherapy with autologous or homologous/allogeneic bone marrow transplant for treatment of any type of cancer not approved for coverage.

7.7 MATERNITY CARE

Prenatal care, childbirth and related conditions are covered when rendered by a professional provider. Professional providers do not include midwives unless they are licensed and certified.

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

Some diagnostic services, such as amniocentesis and fetal stress test, are not part of global maternity services and are reimbursed separately. See section 7.5.10 for gestational diabetes benefits.

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.

7.7.1 Breastfeeding Support

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

7.7.2 Circumcision

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

7.7.3 Diagnostic Procedures

The Plan covers diagnostic services, including laboratory tests and ultrasounds, related to maternity care.

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

7.7.4 Office or Home Visits

A visit means the member is actually examined by a professional provider.

7.7.5 Hospital Benefits

Covered hospital maternity care expenses consist of the following:

- a. **Hospital room.** The actual daily charge
- b. **Facility charges.** When provided at a covered facility, including a birthing center
- c. **Other hospital services and supplies.** Those medically necessary for treatment and ordinarily furnished by a hospital
- d. **Nursery care.** While the mother is confined in the hospital and receiving maternity benefits. Includes one in-nursery physician's visit of a well-newborn infant covered at no cost sharing when performed in-network. Additional visits are covered at the hospital visit benefit level.
- e. **Take-home prescription drugs.** Limited to a 3-day supply at the same benefit level as for hospitalization

Special Right Upon Childbirth (Newborns' and Mothers' Health Protection Act) Benefits for any hospital length of stay 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.

7.7.6 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).

7.8 OTHER SERVICES

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

7.8.1 Durable Medical Equipment (DME), Supplies & Appliances

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

Some examples of DME, supplies and appliances are:

- a. CPAP for sleep apnea
- b. Diabetes pumps and glucometers (see section 7.5.10)
- c. Glasses or contact lenses for the diagnoses of aphakia or keratoconus
- d. Hospital beds and accessories
- e. Intraocular lenses within 90 days following cataract surgery
- f. Light boxes or light wands only when treatment is not available at a provider's office
- g. Orthotics, orthopedic braces, orthopedic shoes to restore or maintain the ability to complete activities of daily living or essential job-related activities. If needed correction or support is accomplished by modifying a mass-produced shoe, then the covered expense is limited to the cost of the modification.
- h. Oxygen and oxygen supplies
- i. Prosthetics

The Plan covers the rental charge (not to exceed the purchase price) for DME. Members can work with their providers to order their prescribed DME. Contact Customer Service for help finding a DME provider.

All supplies, appliances and DME must be medically necessary. Some require prior authorization (see Section 6). Replacement or repair is only covered if the member has established, to the satisfaction of the Plan and Moda Health, that the appliance, prosthetic device, equipment or DME was not abused, was not used beyond its specifications and not used in a manner to void applicable warranties. Upon request, members must authorize any supplier furnishing DME to provide information related to the equipment order and any other records Moda Health requires to approve a claim payment.

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 (examples of Supportive Environmental Materials can be found in Section 8)
- d. Therapeutic devices, except for transcutaneous nerve stimulators
- e. Incontinence supplies
- f. Dental appliances and braces
- g. Supporting devices such as corsets, compression or therapeutic stockings except when such stockings are medically necessary
- h. Testicular prostheses

Neither the Plan nor Moda Health can be held liable for any claim for damages connected with medical conditions arising out of the use of any DME or due to recalled surgically implanted devices or to complications of such devices covered by manufacturer warranty.

7.8.2 Hearing Services

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

The following items are covered once every 36 months:

- a. One hearing aid per hearing impaired ear
- b. Ear molds
- c. Initial batteries, cords and other necessary supplementary equipment
- d. Warranty
- e. Repairs, servicing, or alteration of the hearing aid equipment
- f. Bone conduction sound processors, if necessary for appropriate amplification
- g. Hearing assistive technology system, if necessary for appropriate amplification

In addition:

- a. Replacement ear molds 4 times per year under age 8 and once per year age 8 and older
- b. One box of replacement batteries per year for each hearing aid

The hearing aid must be prescribed, fitted and dispensed by a licensed audiologist or hearing aid specialist with the approval of a licensed physician. A hearing aid may be covered more frequently if modifications to an existing hearing aid cannot meet the needs of a member under age 19.

7.8.3 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:

- e. Registered or licensed practical nurse
- f. Physical, occupational, speech, or respiratory therapist
- g. 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 7.8.4 and 7.8.1.

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

7.8.4 Hospice Care

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

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

Hospice treatment plan means a written plan of care established and periodically reviewed by 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 for medically necessary or palliative care provided by an approved hospice agency to a member who is terminally ill and not seeking further curative treatment for the terminal illness.

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

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

Hospice Inpatient Care The Plan covers short-term hospice inpatient services and supplies.

Respite Care The Plan covers respite care (as defined in Section 14) provided to a member who requires continuous assistance when arranged by the attending professional provider and prior authorized. Benefits are for services provided in what Moda Health determines is the most appropriate setting.

The services and charges of a non-professional provider may be covered for respite care if Moda Health approves in advance.

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

7.8.5 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.

7.8.6 Telemedicine

Covered services, when generally accepted healthcare practices and standards determine they can be safely and effectively provided using synchronous 2-way interactive video conferencing, are covered when provided by a provider using such conferencing. The application and technology used must meet all state and federal standards for privacy and security of protected health information. Benefits are subject to the applicable cost sharing for the covered services.

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

7.9 PHARMACY PRESCRIPTION BENEFIT

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

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

Generic Medications. Generic medications have been determined by the Food and Drug Administration (FDA) to be therapeutically equivalent to the brand alternative and are 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. Some generic medications have not been shown to be safer or more effective than other more cost effective generic medications. These high cost generic medications are excluded unless a formulary exception is requested and approved. See section 7.9.4 for more information about making a formulary exception request.

Nonpreferred Medications. Nonpreferred medications are excluded unless a formulary exception is requested and approved. These medications have been reviewed by Moda Health and do not have significant therapeutic advantage over their preferred alternative(s). These

products generally have safe and effective options available under the Value, Generic and/or Brand tiers. See section 7.9.4 for information about making a formulary exception request.

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.

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

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

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

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

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

A covered expense must be medically necessary, defined as delivery of a service by a qualified healthcare provider, exercising prudent clinical judgement, that meets all of the following:

- a. Is for the purpose of preventing, evaluating, diagnosing or treating a medical condition or its symptoms
- b. Is in accordance with generally accepted standards of medical practice
- c. Is proven to be effective in producing intended effects on health outcomes (e.g., morbidity, mortality, quality of life, symptom control, function) associated with the member's medical condition or its symptoms
- d. Has beneficial effects on health outcomes that outweigh the potential harmful effects
- e. Is clinically appropriate in terms of type, frequency, extent, site and duration
- f. Is not primarily for the convenience of the patient or healthcare provider
- g. Is at least as likely to produce equivalent therapeutic or diagnostic results for the diagnosis or treatment of that patient's medical condition or its symptoms as an alternative service, including no intervention, and is not more costly than an alternative service or sequence of services.

For these purposes, "generally accepted standards of medical practice" are standards based on reliable scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations, and the views of

physicians practicing in relevant clinical areas, and other relevant factors. For new treatments, effectiveness is determined by reliable scientific evidence that is published in peer-reviewed medical literature. For existing treatments, effectiveness is determined first by scientific evidence, then by professional standards, then by expert opinion. The fact that services were furnished, prescribed or approved by a physician or other qualified provider does not in itself mean that services are medically necessary. The fact that a service is FDA-approved does not in itself mean that the service is medically necessary.

7.9.3 Covered Medication Supply

Includes the following:

- a. A prescription 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, and test strips, with a valid prescription
- d. Select prescribed preventive medications required under the Affordable Care Act
- e. Medications for treating tobacco dependence, including OTC nicotine patches, gum or lozenges from an in-network retail pharmacy available with no cost sharing as required under the Affordable Care Act and with a valid prescription
- f. Prescription contraceptive medications and devices for birth control (section 7.4.2) and medical conditions covered under the Plan. Each contraceptive can be dispensed up to a 3-month supply for the member's first use of the medication and up to a 12-month supply for subsequent fills. Contact Customer Service for information on how to obtain a 12-month supply.
- g. Select immunizations and related administration fees are covered with no cost sharing at in-network retail pharmacies (e.g. flu, pneumonia and shingles vaccines)

Certain prescription medications and/or quantities of prescription medications may require prior authorization (see Section 6). For assistance coordinating prescription refills, contact Pharmacy Customer Service.

7.9.4 Formulary Exception Requests

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

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

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

7.9.5 Mail Order Pharmacy

Members have the option of obtaining prescriptions for covered medications through a Moda-designated mail order pharmacy. A mail order pharmacy form can be obtained from the Group, on myModa or by contacting Customer Service.

7.9.6 Specialty Services & Pharmacy

Specialty medications are often used to treat complex chronic health conditions. The pharmacist and other professional providers will advise a member if a prescription requires prior authorization or must be obtained from a Moda-designated specialty pharmacy. Information about the clinical services and a list of eligible specialty medications is available on myModa or by contacting Customer Service.

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

7.9.7 Self-Administered Medication

All self-administered medications are subject to the prescription medication requirements of section 7.9. Self-administered specialty medications are subject to the same requirements as other specialty medications (section 7.9.6).

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

7.9.8 Step Therapy

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

7.9.9 Limitations

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

- a. New FDA approved medications are subject to review and may be subject to additional coverage requirements or limits established by the Plan. A member or prescriber can request a medical necessity evaluation if a newly approved medication is initially denied during the review period.
- b. If a brand medication is dispensed when a generic equivalent is available, the member may be responsible for the difference in cost between the generic and brand medication. Expenses incurred due to brand substitution do not accrue to the out-of-pocket maximum or maximum cost share.
- c. A brand medication is prior authorized for an authorized period or until a generic medication becomes available, whichever comes first. When a generic medication becomes available during an authorized period, the member can get the generic medication without a new prescription or authorization. See bullet b above.
- 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. Some specialty medications that have been determined to have a high discontinuation rate or short durations of use may be limited to a 15-day supply.
- f. Medications with dosing intervals beyond the Plan's maximum day supply will be assessed an increased copayment consistent with the day supply.
- 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. A refill under this provision will be not cover a medication supply beyond the end of the plan year.

7.9.10 Exclusions

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

- 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 7.9.3 and for other devices in section 7.8.1
- c. **Experimental or Investigational Medications.** Including any medication used for an experimental or investigational purpose (see Section 14), 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 while he or she is a patient in a hospital, rest home, skilled nursing facility, extended care facility, nursing home or similar institution
- g. **Medication Administration.** A charge for administration or injection of a medication, except for select immunizations at in-network retail pharmacies
- h. **Medications Covered Under Another Benefit.** Such as medications covered under home health, medical, etc.
- i. **Medications Not Approved by FDA.** Products not recognized or designated as FDA approved medications
- j. **Non-Covered Condition.** A medication prescribed for purposes other than to treat a covered medical condition
- k. **Nutritional Supplements and Medical Foods.**
- l. **Off-label Use.** Medications prescribed for or used for non-FDA approved indications, unless approved by the Health Evidence Review Commission (ORS 414.688) or the Pharmacy Therapeutics and Review Committee (ORS 414.353)
- m. **Over the Counter (OTC) Medications** and prescription medications for which there is an OTC equivalent or alternative, except for those treating tobacco dependence
- n. **Repackaged Medications.**
- o. **Replacement Medications and/or Supplies.**
- p. **Vitamins and Minerals.** Except as required by law
- q. **Weight Loss Medications.**

7.9.11 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 medications 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 a professional provider. Any direct complication or consequence that arises from these exclusions will not be covered except for emergency medical conditions. The Plan does not exclude services solely because an injury results from an act of domestic violence.

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. Related exclusion is under Supportive Environmental Materials.

Cosmetic Procedures

Any procedure or medication requested for the purpose of improving or changing appearance without restoring impaired body function, including rhinoplasty, breast augmentation, lipectomy, liposuction and hair removal (including electrolysis and laser). Exceptions are provided for reconstructive surgery following a mastectomy (Section 8.6.10) or as part of gender identity services (section 8.6.12), and complications of reconstructive surgeries if medically necessary and not specifically excluded.

Court Ordered Sex Offender Treatment

Custodial Care

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

Dental Examinations and Treatment; Orthodontia

Except as specifically provided for in sections 7.5.9 and 7.5.17, 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 (see definition of experimental/investigational in Section 14)

Faith Healing**Family Planning**

Surgery to reverse elective sterilization procedures (vasectomy or tubal ligation)

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 7.8.2

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**Homeopathic Treatment and Supplies****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 may be limited to 115% of the Medicare allowable amount.

Legal Counseling**Massage or Massage Therapy**

Mental Examination and Psychological Testing and Evaluations

For the purpose of adjudication of legal rights, administrative awards or benefits, corrections or social service placement, employment, or any use except as a diagnostic tool for the treatment of a mental health condition or as specifically provided for in section 7.5.6

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, and which includes serious preventable events.

Nuclear Radiation

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

Nutritional Counseling

Except as provided for in sections 7.5.10 and 7.5.20

Obesity or Weight Reduction

Except as covered in section 7.6.2

Orthopedic Shoes

Except as provided for in section 7.8.1

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

School Services

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

Self 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 (including reducing a charge due to a coupon or manufacturer discount), 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 provided at any hospital owned or operated by the state of Oregon or any state approved community mental health and developmental disabilities program
 - ii. veterans of the armed forces, in which case covered services and supplies furnished by the Veterans' Administration of the United States 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 Dysfunction of Organic Origin**

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

Support Education

Including:

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

Supportive Environmental Materials

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

Taxes**Telehealth**

Including telephone visits or consultations and telephone psychotherapy, except telemedicine as specifically provided for in section 7.8.6. This exclusion does not apply to covered case management.

Telephones and Televisions in a Hospital or Skilled Nursing Facility**Therapies**

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

Third Party Liability Claims

Services and supplies for treatment of a medical condition for which a third party is or may be responsible, to the extent of any recovery received from or on behalf of the third party (see section 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, diagnosed mental health or chemical dependence condition, 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 and services continue to meet the criteria for medical necessity (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 purposes other than treating disease
- b. Inappropriate or inconsistent with the symptoms or diagnosis of a member's condition
- c. Not established as the standard treatment by the medical community in the service area in which they are received
- d. Primarily rendered for the convenience of a member or a provider
- e. Not the least costly of the alternative supplies or levels of service that can be safely provided to a member.

The fact that a professional provider may prescribe, order, recommend, or approve a service or supply does not, of itself, make the charge a covered expense.

Treatment Prior to Enrollment

Including services and supplies for an admission to a hospital, skilled nursing facility or other facility that began before the member's coverage under the Plan began. Coverage will only be provided 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. See section 7.5.10 for coverage of annual dilated eye exam for management of diabetes.

Vision Surgery

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

Vitamins and Minerals

Except as required by law. Otherwise, not covered unless medically necessary for treatment of a specific medical condition and prescribed and dispensed by a licensed professional provider under the medical benefit. Applies whether the vitamin or mineral is oral, injectable, or transdermal.

Wigs, Toupees, Hair Transplants

Work Related Conditions

Treatment of a medical condition arising out of or in the course of employment or self-employment for wages or profit, unless the expense is denied as not work related under any workers' compensation provision. A claim must be filed for workers' compensation benefits and a copy of the workers' compensation denial letter must be submitted for payment to be considered. This exclusion does not apply to owners, partners or executive officers if they are

exempt from workers' compensation laws and 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.

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

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. The Plan will pay the provider and send copies of its payment record to the member. The provider will then bill the member for any charges that were not covered.

Sometimes a hospital or professional provider will require a member, at the time of discharge or treatment, to pay charges for a service that the provider believes is not a covered expense. If this happens, the member must pay these amounts if he or she wishes to accept the service. The Plan 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
- f. Provider's tax ID number

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

For care received outside the United States, see section 10.1.4.

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 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.

10.1.4 Out-of-Country or Foreign Claims

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

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

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. The EOB will show if a claim has been paid, denied or accumulated toward satisfying the deductible. If all or part of a claim is denied, the reason will be stated in the EOB.

If a member does not receive an EOB or an email indicating that an EOB is available within a few weeks of the date of service, this may indicate that Moda Health has not received the claim. To be eligible for reimbursement, claims must be received within the claim submission period explained in section 10.1.

10.1.6 Claim Inquiries

Customer Service can answer questions about how to file a claim, the status of a pending claim, or any action taken on a claim. Moda Health will respond to an inquiry within 30 days of receipt.

10.1.7 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.

10.1.8 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

Before filing an appeal, it may be possible to resolve a dispute with a phone call to Customer Service.

10.2.1 Definitions

For purposes of section 10.2, the following definitions apply:

Adverse Benefit Determination means a letter or an Explanation of Benefits (EOB) from Moda Health informing that a person is not eligible for benefits or that benefits have not been fully paid. Reasons include:

- a. Rescission of coverage
- b. Eligibility to participate in the Plan
- c. Limitations or exclusions described in Section 8, including a decision that an item or service is experimental or investigational or not necessary
- d. Utilization review (described below)
- e. Continuity of care (section 10.3) 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 end of the internal appeal process or with respect to which the internal appeal process has been finished.

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

Complaint means an expression of dissatisfaction about a specific problem a member had or about a decision by Moda Health or an agent acting for Moda Health or a provider. It includes a request to resolve the problem or change the decision. Asking for information or clarification about the Plan is not a complaint.

Expedited (fast) appeal means any appeal requested when using the regular time period to review a denial of a pre-service appeal could

- a. Seriously risk a member's life or health or ability to regain maximum function
- b. Would subject the member to severe pain that cannot be managed without the requested care or treatment. A physician with knowledge of a member's medical condition decides this.

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

Pre-service appeal means any appeal for a benefit requested under the Plan for care or services that require prior authorization and the services have not been received.

Utilization Review means a system of reviewing the medical necessity, appropriateness, or quality of medical care services and supplies. 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 is received to submit the first written appeal. If appeals are not submitted within the timeframes outlined in these sections, the member will lose the right to any appeal.

10.2.3 The Review Process

The Plan has a 2-level internal review process (a first level appeal and a second level appeal). If a member is not satisfied with the result of the second level appeal, he or she may ask for external review by an independent review organization. The first and second levels of appeal must be finished before a member can ask for external review, unless the Plan agrees to skip the internal reviews.

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

The timelines in the sections below do not apply when the member does not reasonably cooperate, or circumstances beyond the control of either party (the Plan or the member) makes it impossible to comply with the requirements. Whoever is unable to comply must give notice of the specific reason to the other party when the issue arises.

A member may review the claim file and submit written comments, documents, records and other information to support the appeal. A member may choose a representative to act on his or her behalf.

10.2.4 First Level Appeals

An appeal must be submitted in writing. If necessary, Customer Service can provide assistance filing an appeal. Moda Health will send a letter no more than 7 days after receiving an appeal to tell the member that the appeal is received. Appeals are investigated by persons who were not involved in the original decision.

Expedited appeals can have a faster review upon request. Fast reviews will be finished within 72 hours in total for the first and second level appeals combined after Moda Health has received those appeals. The time between the first level appeal decision and when Moda Health receives the second level appeal does not count. If the member does not provide enough information for Moda Health to make a decision at each appeal level, Moda Health will tell the member and/or provider within 24 hours of receipt of the appeal of the specific information needed to make a decision. The member or provider must provide the specified information as soon as possible. Moda Health will make a decision on a fast appeal no later than 48 hours after the earlier of (a) Moda Health's receipt of the specified information, or (b) the end of the time allowed to submit the specified additional information.

When an investigation is finished, Moda Health will send a written notice of the decision to the member, including the reason for the decision. 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 on the first level appeal may ask for 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 decisions, and will follow the same timelines as those for a first level appeal. If new or additional evidence or reasoning is used by Moda Health in connection with the appeal, 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 decision is finalized. Moda Health will send a written notice of the decision to the member, including the reason for the decision.

10.2.6 External Review

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

- a. The members must sign a HIPAA release waiver allowing the IRO to see his or her medical records.
- 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 IRO within 5 days, or 24 hours for a fast review.
- c. Generally, the member must have exhausted the appeal process described in sections 10.2.4 and 10.2.5. However, Moda Health may agree to skip this requirement and send an appeal directly to external review if the member agrees. For a fast appeal or when the appeal is about a condition for which a member received emergency services and is still hospitalized, a request for external review may be expedited at the same time as a request for internal appeal review.
- d. 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 IRO 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 review complaints about 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 healthcare services that is not appealing an adverse benefit determination
- c. The contractual relationship between a member and Moda Health.

Review of a complaint will be completed within 30 days. If more time is needed, Moda Health will tell the member and have 15 more days to make a decision.

10.2.8 Additional Member Rights

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

10.3 CONTINUITY OF CARE

10.3.1 Continuity of Care

Sometimes a provider's contract with the network ends. On the day a professional provider's contract with Moda Health ends, he or she becomes an out-of-network provider. When this happens, Moda Health may cover some services by the professional provider as if he or she were still in network for a limited period of time. This is called continuity of care.

Eligible members

- a. Will get a letter from Moda Health
 - i. 30 days before the contract ends or as soon as Moda Health knows the contract is ending, or
 - ii. no more than 10 days after Moda Health first learns that a member had been seeing that provider for ongoing care
 - iii. When the professional provider is part of a group of providers, the provider group may give this notice
 - iv. When a member requests continuity of care before Moda Health sends its notice, the member is considered notified as of that date
- b. Are under the care of a professional provider whose contract with Moda Health ends
 - i. The care is an active course of treatment that is medically necessary
 - ii. Pregnancy care is in at least the second trimester
 - iii. The professional provider and the member agree that it is a good idea to maintain continuity of care
- c. Request continuity of care from Moda Health

The professional provider must agree to follow the requirements of the medical services contract that had most recently been in effect between the professional provider and Moda Health, and to accept the contractual reimbursement applicable at the time the contract ended.

Continuity of care ends

- a. On the earlier of the following dates for most members:
 - i. The day after the member finishes the active course of treatment that gives him or her the right to continuity of care
 - ii. 120 days after the date Moda Health tells the member the contract with the professional provider has ended
- b. On the later of the following dates for pregnancy care that is in at least the 2nd trimester:
 - i. 45 days after the birth
 - ii. As long as the member continues under an active course of treatment, but not later than 120 days after the date Moda Health tells the member the contract with the professional provider has ended

When continuity of care is not available:

- a. The member leaves the Plan
- b. The Group ends the Plan
- c. The professional provider has moved out of the service area
- d. The professional provider cannot continue to care for patients because of other reasons
- e. The contract with the professional provider ended for reasons related to quality of care and he or she has finished any appeals process

10.3.2 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 the Plan 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 the Plan.

10.4.1 Coordination of Benefits (COB)

This provision applies when a member has healthcare coverage under more than one plan.

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.

10.4.1.1 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 or are living together whether or not they have ever been married or domestic partners, the plan of the parent whose birthday falls earlier in the calendar year is the primary plan. If both parents' birthdays are on the same day, the plan that has covered the parent the longest is the primary plan. (This is called the birthday rule.)
- c. **Dependent Child/Parents Separated or Divorced or Not Living Together.** If the member is a dependent child of divorced or separated parents, or parents not living together whether or not they have ever been married or domestic partners, then the following rules apply:
 - i. If a court decree states that one of the parents is responsible for the healthcare expenses of the child, and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to plan years commencing after the plan is given notice of the court decree.
 - ii. If a court decree states that both parents are responsible for the healthcare expenses of the child, or that the parents have joint custody without specifying that one parent is responsible, the birthday rule described above applies.
 - iii. If there is not a court decree allocating responsibility for the child's healthcare expenses, the order of benefits is as follows: The plan covering the
 - A. Custodial parent
 - B. Spouse or domestic partner of the custodial parent
 - C. Non-custodial parent
 - D. Spouse or domestic partner of the non-custodial parent
- d. **Dependent Child Covered by Individual Other than Parent.** For a dependent child covered under more than one plan of persons who are not the parents of the child, the first applicable provision (b. or c.) above shall determine the order of benefits as if those persons were the parents of the child.
- e. **Dependent Child Coverage by Parent and Spouse.** For a dependent child covered under the plans of both a parent and a spouse or domestic partner, the length of coverage provision below shall determine the order of benefits. If coverage under either or both parents' plans and the spouse's/domestic partner'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.

10.4.1.2 How COB Works

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

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

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

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

10.4.1.3 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.

10.4.1.4 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 10.1.3).

The manner in which a pharmacy claim is paid by the primary payer will affect how the Plan 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, the Plan will pay as if it is primary.

Primary plan pays benefits. In this scenario, the Plan will pay up to what it 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.

10.4.1.5 Definitions

For purposes of section 10.4.1, the following definitions apply:

Plan means any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for covered persons in a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

Plan includes:

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

Plan does not include:

- a. Hospital indemnity coverage or other fixed indemnity coverage
- b. Accident-only coverage
- c. Specified disease or specified accident coverage
- d. School accident coverage
- e. Benefits for non-medical components of group long-term care policies
- f. Medicare supplement policies

- g. Medicaid policies
- h. Coverage under other federal governmental plans, unless permitted by law

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

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

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

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

Allowable expense means a healthcare expense, including cost sharing, that is covered at least in part by any plan covering the member. When a plan provides benefits in the form of a service rather than cash payments, the reasonable cash value of the service will also be considered an allowable expense and a benefit paid. An expense that is not covered by any plan covering the member is not an allowable expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a member is not an allowable expense.

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

- a. The difference between the cost of a semi-private hospital room and a private hospital room, unless one of the plans provides coverage for private hospital room expenses
- b. The amount of the reduction by the primary plan because a member has failed to comply with the plan's provisions concerning second surgical opinions or prior authorization, or because the member has a lower benefit due to not using an in-network provider
- c. Any amount in excess of the highest reimbursement amount for a specific benefit, if a member is covered by 2 or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology
- d. Any amount in excess of the highest of the negotiated fees, if a member is covered by 2 or more plans that provide benefits or services on the basis of negotiated fees
- e. If a member is covered by one plan that calculates its benefits on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another plan that provides its benefits on the basis of negotiated fees, the primary plan's arrangement shall be the allowable expense for all plans. However, if the provider has contracted with the secondary plan to provide the benefit 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 health plan funded by the Group 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 this group health plan providing healthcare benefits is separate from this Plan. A group health plan may apply one COB provision to certain benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

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

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

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 the Plan. 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 the Plan will pay a member's expenses based on the understanding and agreement that the Plan 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 the Plan has the rights described in section 10.4.2. The Plan 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, the Plan'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 the Plan, 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, the Plan 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. The Plan is entitled to all subrogation rights and remedies under common and statutory law, as well as under the Plan's provisions.

10.4.2.3 Right of Recovery

In addition to its subrogation rights, the Plan 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 the Plan, but only for the amount of benefits the Plan paid for that medical condition.
- b. The Plan 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, the Plan is entitled to receive the amount of benefits it has paid whether the health care expenses are itemized or expressly excluded in the third party recovery.
- c. If the Plan requires 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 the Plan 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 the Plan, 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. The Plan's recovery rights will not be reduced due to the member's own negligence.
- e. If it is reasonable to expect that the member will incur future expenses for which benefits might be paid by the Plan, the member shall seek recovery of such future expenses in any third party claim.
- e. In third party claims involving the use or operation of a motor vehicle, the Plan, 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 the Plan may do one or more of the following at its discretion:

- a. The member shall cooperate with Moda Health to protect the Plan's recovery rights, including by:
 - i. Signing and delivering any documents Moda Health reasonably requires to protect the Plan's 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 the Plan's 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 the Plan's 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 the Plan's 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 the Plan whether or not the event giving rise to the member's injuries occurred before the member became covered by the Plan.
 - 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 the Plan 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 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 under Medicare or would have been paid under Medicare Part B if the member was 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. Examples of when the Plan may estimate Medicare's payment include members under age 65 and disabled and the group has fewer than 100 employees, or members who are age 65 or older and all employers in the group have fewer than 20 employees. A member who chose not to enroll in Medicare when first eligible or canceled Medicare after initial enrollment may have to pay any expenses not paid by the Plan.

In addition, if the Plan is secondary to Medicare, the Plan 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. MISCELLANEOUS PROVISIONS

11.1 RIGHT TO COLLECT & 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.

11.2 CONFIDENTIALITY OF MEMBER INFORMATION

Keeping a member's protected health information confidential is very important to the Plan. Protected health information includes enrollment, claims, and medical and dental information. Such information is used 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 the Group uses members' information. Moda Health, as the claims administrator, is required to follow these same practices. Members may contact the Group if they have additional questions about the privacy of information beyond what is provided in the Notice of Privacy Practices.

11.3 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, or the Plan, except that the Plan shall pay amounts due under the Plan directly to a provider when billed by a provider licensed, certified or otherwise authorized by laws in the state of Oregon or upon a member's written request.

11.4 RECOVERY OF BENEFITS PAID BY MISTAKE

If the Plan 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, the Plan has the right to recover the payment from the person paid or anyone else who benefited from it, including a provider. The Plan's right to recovery includes the right to deduct the amount paid from future benefits it would provide for a member even if the mistaken payment was not made on that member's behalf.

11.5 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.

11.6 CONTRACT PROVISIONS

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

11.7 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, benefits under the Plan reduced by any benefits payable by the prior plan, will apply. 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.

11.8 RESPONSIBILITY FOR QUALITY OF MEDICAL CARE

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

11.9 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 the member's beneficiary.

11.10 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.

11.11 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.

11.12 COMPLIANCE WITH FEDERAL & STATE MANDATES

The Plan provides benefits in accordance with the requirements of all applicable state and federal laws, and state laws when applicable to the Group and as described in the Plan. This includes compliance with federal mental health parity requirements.

11.13 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.

11.14 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.

11.15 TIME LIMITS FOR FILING A LAWSUIT

Any legal action arising out of, or related to, the Plan and filed against the Plan 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.

11.16 EVALUATION OF NEW TECHNOLOGY

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

SECTION 12. 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.

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

12.1.1 Introduction

55+ Oregon Continuation only applies to employers with 20 or more employees. The Plan will provide 55+ Oregon Continuation coverage to those members who elect it, subject to the requirements of section 12.1.

12.1.2 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

12.1.3 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 member 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, the Group shall give the designated third party administrator, if any, written notice of the death and the mailing address of the eligible 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 does not 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. If the election is not made within 60 days of the notification, the member will lose the right to continued benefits under this section.

12.1.4 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.

12.1.5 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 ends, unless a different group health plan 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
- e. The date the member becomes eligible for Medicare

12.2 COBRA CONTINUATION COVERAGE

12.2.1 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. The Plan 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 an exception for domestic partner coverage, the Plan will offer no greater COBRA rights than the COBRA statute requires
- b. The Plan will not provide COBRA coverage for those members who do not comply with the notice, election or other requirements outlined below

For purposes of section 12.2, COBRA Administrator means either the Group or a third party administrator delegated by the Group to handle COBRA administration.

12.2.2 Qualifying Events

Subscriber. A subscriber may elect continuation coverage if coverage is lost because of termination of employment (other than termination for gross misconduct, 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. Subscriber becomes entitled to Medicare

(If it can be established that a subscriber has eliminated 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 divorce or legal separation, 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. Subscriber becomes entitled to Medicare
- e. 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 has 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.

12.2.3 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.

12.2.4 Notice & Election Requirements

Qualifying Event Notice. A dependent member's coverage ends 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, 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 coverage will end.

A subscriber or the spouse may elect continuation coverage for eligible family members. Each family member also 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.

12.2.5 COBRA Premiums

Members are responsible for all premiums for continuation coverage. Due to the 60-day election period, it is likely that retroactive premiums will be owed for the months between when regular coverage ended and the first payment date. These premiums must be paid in a lump sum at the first payment. 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). Subsequent payments are due on the first day of the month. There will be a grace period of 30 days to pay the premiums. The Plan will not send a bill for any payments due. The member is responsible for paying the applicable premiums 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.

12.2.6 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. When coverage is lost 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 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.

12.2.7 Extending the Length of COBRA Coverage

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 does not provide notice of a disability or second qualifying event, he or she 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 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 Social Security Administration determination is within the 18-month period following the subscriber's termination of employment or reduction of hours. The member must provide a copy of the Social Security Administration's determination of disability to the COBRA Administrator 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

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 premium.

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. 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 is only available only if the COBRA Administrator is notified in writing of the second qualifying event within 60 days after the date of the 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 12.1).

12.2.8 Newborn or Adopted Child

If 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 coverage. If the COBRA Administrator is not notified in the required time, the child will not be eligible for coverage.

12.2.9 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.

12.2.10 When Continuation Coverage Ends

COBRA coverage will end earlier than 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 12.2.7), 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 canceled 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.

12.3 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 the Group 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 13. MEMBER DISCLOSURES

The intent of these disclosures is to assure, among other things, that patients and providers are informed about their health insurance plans.

13.1 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 the Plan, 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. Change to a new medical home primary care physician (PCP)
- h. File a complaint or appeal about any aspect of the plan, and to receive a timely response. Members are welcome to make suggestions to Moda Health.
- i. Obtain free language assistance services, including verbal interpretation services, when communicating with Moda Health
- j. Have a statement of wishes for treatment, known as an Advanced Directive, on file with their professional providers. Members also have the right to file a power of attorney, which allows the member to give someone else the right to make healthcare choices when the member is unable to make these decisions.
- k. Make suggestions regarding the Plan'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 the Plan 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.

13.2 The Plan requires members to select a medical home PCP and for thir medical home PCP to coordinate all healthcare needs. How does a member know when he or she needs a referral?

Referrals are not required. When medically necessary, the medical home PCP will direct a member to an in-network provider for specialized care or services.

13.3 What if a member has a medical emergency?

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

A member does not need to contact his or her medical home PCP prior to seeking emergency treatment. However, the member should contact the PCP as soon as reasonably possible after seeking emergency care. Members are covered anywhere in the world for medical emergency treatment. Additional information is in section 7.3.

13.4 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.

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

If a member’s PCP ends his or her participation in the network, Moda Health will inform the member and provide instructions on how to select a new medical home PCP.

13.6 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 can be found in section 10.2.

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

13.7 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.

13.8 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

13.9 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.

13.10 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 more information.

SECTION 14. 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.

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

Applied Behavior Analysis means a variety of psychosocial interventions that use behavioral principles to shape an individual's behavior. It includes direct observation, measurement and functional analysis of the relationship between environment and behavior. It is a type of treatment for individuals with autism spectrum disorder. Typical goals include improving daily living skills, decreasing harmful behavior, improving social functioning and play skills, improving communication skills and developing skills that result in greater independence.

Authorization see Prior Authorization.

Autism Service Provider means a behavior analyst licensed by the Oregon Behavior Analysis Regulatory Board (BARB), an assistant behavior 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. In states that do not license autism service providers, certification or registration with the Behavior Analysis Certification Board may be accepted instead.

Balance Billing means the difference between the maximum plan allowance and the provider's billed charge. Out-of-network providers may bill the member this amount, except Oregon-licensed providers when performing services at an in-network facility and the member did not choose the provider. Balance billing is not a covered expense under the Plan.

Behavioral Health Assessment means an evaluation by a behavioral health clinician, in person or using telemedicine, to determine a person's need for immediate crisis stabilization.

Behavioral Health Crisis means a disruption in a person's mental or emotional stability or functioning resulting in an urgent need for immediate outpatient treatment in an emergency department or admission of a hospital to prevent a serious deterioration in the person's mental or physical health.

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

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

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

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

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

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

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

Custodial Care means care that helps a member conduct such common activities as bathing, eating, dressing or getting in and out of bed. It is care that can be provided by people without medical or paramedical skills. Custodial care includes care that is primarily for the purpose of keeping a member safe or for holding a member awaiting admission to the appropriate level of care.

Dental Care means services or supplies provided to prevent, diagnose, or treat diseases of the teeth and supporting tissues or structures, including services or supplies 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 or behavioral health crisis with acute symptoms, including severe pain, that a prudent layperson with an average knowledge of health and medicine could reasonably expect that failure to receive immediate medical attention would place the health of a member, or a fetus in the case of a pregnant woman, in serious jeopardy.

Emergency Medical Screening Examination means the medical history, examination (which may include behavioral health assessment), related tests and medical determinations required to confirm the nature and extent of an emergency medical condition.

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

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.

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

- a. Involve a treatment for which scientific or medical assessment has not been completed, or the effectiveness of the treatment has not been generally established
- b. Are available in the United States only as part of clinical trial or research program for the illness or condition being treated
- c. Are not provided by an accredited institution or provider within the United States or are provided by one that has not demonstrated medical proficiency in the provision of the service or supplies
- d. Are not recognized by the medical community in the service area in which they are received
- e. Involve a treatment for which the approval of one or more government agencies is required, but has not been obtained at the time the services and supplies are provided or are to be provided

Experimental or Investigational Medications are those that involve one or more of the following:

- a. A medication, device (supply) or biologic product for which the approval of one or more government agencies (such as the FDA) is required, but has not been obtained at the time the treatment is requested or administered
- b. A treatment for which scientific or medical assessment has not been completed, or the effectiveness of the treatment has not been generally established
- c. Is only available in the United States as part of a clinical trial or research program for the illness or condition being treated
- d. Is the subject of an on-going phase I or phase II clinical trial, or is the research/experimental/study/investigational arm of an on-going phase III clinical trial
- e. Is used within a regimen that may be individually proven, but when utilized in combination, scientific literature does not support the use
- f. Is used within a regimen that is proven in combination with other medications, but when utilized individually, scientific literature does not support the use

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

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

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 service.

Implant means a material inserted or grafted into tissue.

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

In-Network refers to medical home providers that are contracted under Moda Health to provide care to members.

Intensive Outpatient means mental health or chemical dependency services more intensive than outpatient and less intensive than a partial hospital program. Mental health intensive outpatient is 3 or more hours per week of direct treatment. Chemical dependency intensive outpatient is 9-19 hours per week for adults or 6-19 hours per week for adolescents.

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

MPA for out-of-network services is the lesser of a supplemental provider fee arrangement Moda Health may have in place or the amount calculated using one of the following methodologies, any of which may be used by the Plan: a percentage of the Medicare allowable, a percentile of fees commonly charged for a given procedure in a given area, a percentage of the acquisition cost or a percentage of the billed charge.

MPA for emergency services received out-of-network is the greatest of the median in-network rate, the maximum amount as calculated according to this definition for out-of-network facility and the Medicare allowable amount.

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

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

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

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

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

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

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

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

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

Medically necessary care does not include custodial care.

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

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 health conditions, as defined in the Plan.

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

Mental Health Provider means a board-certified psychiatrist, or any of the following state-licensed professionals: a psychologist, a psychologist associate, a psychiatric mental health nurse practitioner, a clinical social worker, a mental health counselor, a marriage and family therapist or a program licensed, approved, established, maintained, contracted with or operated by the Oregon Office of Mental Health & Addiction Services.

Moda Health refers to Moda Health Plan, Inc. Moda Health is the claims administrator of the Plan. References to Moda Health as paying claims or issuing benefits mean that Moda Health processes a claim and the Plan Sponsor reimburses Moda Health any benefit issue.

Network means a group of providers who contract to provide healthcare to members at negotiated rates. Covered medical expenses will be paid at a higher rate when an in-network provider is used (see Section 3).

Out-of-Network refers to providers that are not contracted under Moda Health to charge discounted rates to members.

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

Partial Hospital Program means an appropriately licensed mental health or chemical dependency facility providing no less than 4 hours of direct, structured treatment services per day. Chemical dependency partial hospital programs provide 20 or more hours of direct treatment per week. Partial hospital programs do not provide overnight 24-hour per day care.

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

Plan Sponsor means the Group.

Primary Care Physician (PCP) is the in-network physician or women's healthcare provider a member chooses to be responsible for his or her continuing medical care. Moda Health reserves the right to establish the maximum number of in-network PCPs necessary to serve a defined population or geographic service area.

Prior Authorization or **Prior Authorized** refers to obtaining approval by Moda Health prior to the date of service. A complete list of services and medications that require prior authorization is available on myModa or by contacting Customer Service. Failure to obtain required authorization will result in denial of benefits (see Section 6).

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

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

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

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

Service Area is the geographical area, including Benton, Clackamas, Clatsop, Columbia, Coos, Crook, Curry, Deschutes, Douglas, Hood River, Jackson, Jefferson, Josephine, Klamath, Lane,

Lincoln, Linn, Marion, Multnomah, Polk, Tillamook, Wasco Washington and Yamhill, where in-network providers provide their services.

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

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. A women's healthcare provider designated as a PCP must meet certain standards and must have requested designation from Moda Health as a PCP.



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

P.O. Box 40384
Portland, OR 97240

Moda does not discriminate

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

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

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

If you need any of the above, call Customer Service at:

888-217-2363 (TDD/TTY 711)

If you think we did not offer these services or discriminated, you can file a written complaint.

Please mail or fax it to:

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

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

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

U.S. Department of Health
and Human Services
200 Independence Ave. SW, Room 509F
HHH Building, Washington, DC 20201
800-368-1019, 800-537-7697 (TDD)

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

Dave Nessler-Cass coordinates our nondiscrimination work:

Dave Nessler-Cass,
Chief Compliance Officer
601 SW Second Ave.
Portland, OR 97204
855-232-9111
compliance@modahealth.com

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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