Oregon
Group Medical Plan

Chemeketa Community College

Standard Plan

Preferred Provider (PPO) Plan

Effective Date: January 1, 2016

Group Number: 10012543

modahealth.com

Health plans in Oregon by Moda Health Plan, Inc.

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SECTION 1. WELCOME

Moda Health is pleased to have been chosen by the Group as its preferred provider organization (PPO) plan. This handbook is designed to provide members with important information about the Plan's benefits, limitations and procedures.

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

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

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

1.1 MEMBER RESOURCES

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

Medical Customer Service Department
Portland 503-243-3962; Toll-free 888-217-2363
En Español 503-265-2961; Llamado gratis 888-786-7461

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

Pharmacy Customer Service Department
Portland 503-265-2939; Toll-free 888-361-1610

Telecommunications Relay Service for the hearing impaired
711

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

SECTION 2. SUMMARY OF BENEFITS – A QUICK REFERENCE

This section is a quick reference summarizing the Plan's benefits. The details of the actual benefits and the conditions, limitations and exclusions of the Plan are contained in the sections that follow. An explanation of important terms is found in Section 5.

Section 3.1 provides information regarding prior authorization requirements. Members can access a complete list of procedures that require prior authorization on myModa or by contacting Customer Service. Failure to obtain required prior authorizations may result in denial of benefits.

2.1 NETWORK INFORMATION

In-network benefits apply to services delivered by in-network providers; out-of-network benefits apply to services delivered by out-of-network providers. By using an in-network provider, members will receive quality healthcare and will have a higher level of benefits. Members may choose an in-network provider by using "Find Care" on myModa or by contacting Customer Service for assistance. Member ID cards will identify the applicable network(s).

2.1.1 Primary Network; Primary Service Area

All members will have access to a primary network, which provides services in their primary service area. Additional networks may also be available to members if the subscriber resides outside the primary service area. Subscribers who move outside of a network service area must contact Customer Service to find out if another network is available to ensure continued access to in-network providers.

Networks
For all members:
Medical Network is Connexus Network in Oregon, southwest Washington and Idaho
Pharmacy network is MedImpact

2.1.2 Coverage Outside the Service Area for Children

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

a. All non-emergency hospital confinements must be prior authorized
b. Services will be paid at the in-network benefit level if provided within a 30-mile radius of the child's residence or at the closest appropriate facility
c. Services will be paid at the out-of-network benefit level if such services are provided outside the 30-mile radius of the child's residence
d. Out-of-area and out-of-network providers may bill members for charges in excess of the maximum plan allowance
e. Out-of-pocket expenses for services performed by providers outside the service area will not accrue toward the annual out-of-pocket maximum

2.1.3 Travel Network

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

provider if members are outside the primary service area and the travel is not for the purpose of receiving treatment or benefits. The travel network is not available to members whose assigned network provides nationwide access.

Travel Network
Healthy Directions

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

2.1.4 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.

2.2 SCHEDULE OF BENEFITS

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

Annual deductible per member	**$ 650**
Maximum annual family aggregate deductible	**$1,950**
Annual out-of-pocket maximum per member	**$3,000**
Maximum annual aggregate out-of-pocket maximum per family	**$9,000**

Services	**Cost Sharing** (Deductible applies unless noted differently)		**Section in Handbook & Details**
	In-network	**Out-of-network**	
Emergency Care			
Emergency Room Facility	$200 per visit then 20%, deductible waived	$200 per visit then 20%, deductible waived	Section 6.3 Copay waived if covered hospitalization immediately follows emergency room use.

Services	Cost Sharing (Deductible applies unless noted differently)		Section in Handbook & Details
	In-network	Out-of-network	
Hospital Care and Residential Facility Care			
Inpatient Acute Care	20%	40%	Section 6.4.3
Inpatient Rehabilitation and Habilitation	20%	40%	Section 6.4.4
Skilled Nursing Facility Care	20%	40%	Section 6.4.5
Residential Mental Health & Chemical Dependency Treatment Programs	20%	40%	Section 6.4.6
Chemical Dependency Detoxification	20%	40%	Section 6.4.7
Ambulatory Services			
Outpatient Surgery and Invasive Diagnostic Procedures (Facility Charges)	20%	40%	Section 6.5.1
Outpatient Rehabilitation and Habilitation	20%	40%	Section 6.5.2
Infusion Therapy (Home or Outpatient)	20%	40%	Section 6.5.3
Diagnostic Procedures, including x-ray and lab	20%	40%	Section 6.5.4
Therapeutic X-ray	20%	40%	Section 6.5.5
Kidney Dialysis	20%	40%	Section 6.5.5
Imaging Procedures	20%	40%	Section 6.5.6
Outpatient Chemical Dependency Services	20%, deductible waived	40%	Section 6.5.7
Professional Services			
Preventive Healthcare			
Services as required under the Affordable Care Act, including the following:	No cost sharing	Not covered unless otherwise stated	Section 6.6.1
Periodic Health Exams	No cost sharing	Not covered	7 exams from age 1 to 4 One per year, age 5+
Immunizations	No cost sharing	Not covered	
Newborn Hearing Screening	No cost sharing	Not covered	
Routine Vision Screening	No cost sharing	Not covered	Age 3 to 5
Women's Exam & Pap Test	No cost sharing	40%	One per year
Routine Mammogram	No cost sharing	40%	One per year, age 40+

Services	Cost Sharing (Deductible applies unless noted differently)		Section in Handbook & Details
	In-network	Out-of-network	
Routine Colonoscopy	No cost sharing	Not covered	One per 10 years, age 50+
Routine Diagnostic X-ray & Lab	20%, deductible waived when outpatient or in professional provider office setting	Not covered	
Prostate Rectal Exam	20%, deductible waived	40%	One per year, age 50+
Prostate Specific Antigen (PSA) Test	20%, deductible waived when outpatient or in professional provider office setting	40%	One per year, age 50+
Home and Office Visits	$30 per visit, deductible waived	40%	Section 6.6.2
Urgent Care Office Visits	$30 per visit, deductible waived	40%	Section 6.6.2
Specialist Visits (including naturopath visits)	$40 per visit, deductible waived	40%	Section 6.6.2
Physician Hospital Visits	20%	40%	Section 6.6.2
Outpatient Diabetic Instruction	20%	40%	Section 6.6.3 Once, following diagnosis
Therapeutic Injections	20%	40%	Section 6.6.4
Surgery	20%	40%	Section 6.6.5
Special Dental Care	20%	40%	Section 6.6.10 $5,000 lifetime maximum for implants
Temporomandibular Joint Syndrome	20%	40%	Section 6.6.12
Applied Behavior Analysis			Section 6.6.13
Office Visits	20%, deductible waived	40%	
Other Services	20%	40%	
Outpatient Mental Health Services	20%, deductible waived	40%	Section 6.6.14
Tobacco Cessation Treatment			Section 6.6.17 Age 10+
Consultation	No cost sharing	Not covered	
Supplies	No cost sharing	40%	

Services	Cost Sharing (Deductible applies unless noted differently)		Section in Handbook & Details
	In-network	Out-of-network	
Alternative Care (Spinal Manipulation, Acupuncture, Naturopathic Substances)	20%, deductible waived	20%	Section 6.6.19
Other Services			
Ambulance Transportation	20%	20%,	Section 6.7.1
Hospice Care			Section 6.7.2
Home Care	20%	40%	
Inpatient Care	20%	40%	
Respite Care	20%	40%	
Maternity	20%	40%	
Breastfeeding Support, Supplies and Counseling	No cost sharing	No cost sharing	Section 6.7.4
Transplants			Section 6.7.5
Exclusive transplant network facilities	20%	40%	
Other facilities	20%	20%	
Biofeedback	$40 per visit, deductible waived	40%	Section 6.7.6
Home Healthcare	20%	40%	Section 6.7.7
Outpatient Durable Medical Equipment	20%	40%	Section 6.7.8
Supplies and Appliances	20%	40%	Section 6.7.8
Disposable Supplies (provided in a professional provider's office)	20%	40%	Section 6.7.8
Hearing Aids and Related Services	20%	20%	Section 6.7.9 Once every 48 months. For members under age 26
Medications			
Anticancer Medication	10%	40%	Section 6.8.2 Deductible waived if purchased at pharmacy
Prescription Medication			Section 6.9 $100 individual
Retail Pharmacy			Up to 30-day supply per prescription
Value Tier	No Charge	No Charge	Deductable Waived

Services	Cost Sharing (Deductible applies unless noted differently)		Section in Handbook & Details
	In-network	Out-of-network	
Generic Tier	$20	$20	No charge for drugs designated as preventive for treatment of chronic diseases
Preferred Tier	$50	$50	
Brand Tier	$100	$100	
Mail Order Pharmacy			Up to 90-day supply per prescription
Value Tier	No Charge	N/A	
Select Tier	$60	N/A	
Preferred Tier	$150	N/A	
Brand Tier	$300	N/A	
Specialty Pharmacy			Up to 30-day supply per prescription
Specialty Select	$20	N/A	
Specialty Preferred	$50	N/A	
Specialty Brand	$100	N/A	

2.3 DEDUCTIBLES

The Plan has an annual deductible. The deductible amounts are shown in section 2.2, and are the amount of covered expenses that are paid by members before benefits are payable by the Plan. After the deductible has been satisfied, benefits will be paid according to section 2.2. When a per member deductible is met, benefits for that member will be paid according to section 2.2. If coverage is for more than one member, the per member deductible applies only until the total family deductible is reached.

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

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

If covered expenses 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 for the following year.

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

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

2.4 ANNUAL MAXIMUM OUT-OF-POCKET

After the annual per member or per family out-of-pocket maximum is met, the Plan will pay 100% of covered services for the remainder of the year. If coverage is for more than one member, the per member maximum applies only until the total family out-of-pocket maximum is reached.

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. Cost containment penalties
b. Disallowed charges

Except as noted below, out-of-pocket costs for services performed by an in-network provider accumulate toward the annual out-of-pocket maximum. If coverage is for more than one member, the per member maximum applies only until the total family out-of-pocket maximum is reached. After the per member or per family out-of-pocket maximum is met, the Plan will pay 100% of covered services performed by an in-network provider for the remainder of the year. For out-of-network providers, the Plan will continue to pay as shown in section 2.2.

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. Disallowed charges
b. Cost containment penalties
c. Services performed by out-of-network providers

2.5 PAYMENT

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

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

SECTION 3. COST CONTAINMENT

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

3.1 PRIOR AUTHORIZATION REQUIREMENTS

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

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

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

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

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

3.1.1 Inpatient Services and Residential Programs

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

Authorization for emergency hospital admissions must be obtained by calling Moda Health within 48 hours of the emergency hospital admission (or as soon as reasonably possible).

3.1.2 Ambulatory Surgery and Other Outpatient Services

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

In-network providers who perform advanced imaging services are responsible for obtaining prior authorization on the member's behalf. Members using an out-of-network provider are responsible for ensuring that their provider contacts Moda Health for prior authorization. Services not authorized in advance will be denied. The in-network provider is expected to write off the full charge of the service. If the provider is out-of-network, the full charge will be the member's responsibility.

3.1.3 Prescription Medication

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

Prior authorization programs are not intended to create barriers or limit access to medications. Medications requiring prior authorization are evaluated with respect to evidence based criteria that align with medical literature, best practice clinical guidelines and guidance from the FDA. Requiring prior authorization ensures member safety, promotes proper use of medications and supports cost effective treatment options for members.

3.2 SECOND OPINION

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

3.3 COST EFFECTIVENESS SERVICES

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

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

SECTION 4. CARE COORDINATION

4.1 CARE COORDINATION

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

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

4.2 DISEASE MANAGEMENT

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

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

Call toll-free: 877-277-7281

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

SECTION 5. DEFINITIONS

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

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

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

Authorization see Prior Authorization.

Autism Service Provider means a behavior analyst licensed by the Oregon Behavior Analysis Regulatory Board (BARB), an assistant behavior analysis licensed by BARB and practicing under the supervision of a behavior analyst, and interventionist registered by BARB and practicing under the supervision of a behavior analyst, or a state-licensed or state-certified healthcare professional providing services for autism spectrum disorder within the scope of his or her professional license.

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

Chemical Dependency means an addictive relationship with any drug or alcohol characterized by a physical and/or psychological relationship that interferes on a recurring basis with an individual's social, psychological or physical adjustment to common problems. Chemical dependency does not mean an addiction to or dependency upon foods, tobacco, or tobacco products.

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

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

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

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

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

Custodial Care means care that helps a member conduct such common activities as bathing, eating, dressing or getting in and out of bed. It is care that can be provided by people without medical or paramedical skills. Custodial care also includes care that is primarily for the purpose of separating a member from others, or for preventing a member from harming himself or herself.

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

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

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

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

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

Eligible Employee means any employee or former employee of the Group who meets the eligibility requirements to be enrolled on the Plan (see Section 8).

Emergency Medical Condition means a medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson possessing an average knowledge of health and medicine could reasonably expect that failure to receive immediate medical attention would place the health of a member, or a fetus in the case of a pregnant woman, in serious jeopardy.

Emergency Medical Screening Examination means the medical history, examination, ancillary tests and medical determinations required to ascertain the nature and extent of an emergency medical condition.

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

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

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

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

Experimental or Investigational means services and supplies that:

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

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

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

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

Health Benefit Plan means any hospital and/or medical expense policy or certificate, healthcare service contractor or health maintenance organization subscriber contract, any plan provided by a multiple employer welfare arrangement, or other benefit arrangement defined in the federal Employee Retirement Income Security Act of 1974, as amended.

Illness means a disease or bodily disorder that results in a covered expense.

Implant means a material inserted or grafted into tissue.

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

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

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

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

MPA for an out-of-network provider other than a facility is the lesser of the amount payable under any supplemental provider fee arrangements Moda Health may have in place and the 75th percentile of fees commonly charged for a given procedure in a given area, based on a national database. If a dollar value is not available in the national database, Moda Health will consider 75% of the billed charge as the MPA. In certain instances, when a dollar value is not

available in the database, the claim is reviewed by Moda Health's medical consultant, who determines a comparable code to the one billed. Once a comparable code is established, the claim is processed as described above.

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

MPA for out-of-network dialysis facilities is 125% of the Medicare allowable amount.

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

MPA for medical devices, including implanted devices, and for durable medical equipment is the contracted amount, or the lesser of 100% of the Medicare allowable amount or the acquisition cost of the device plus 10% if there is no contracted amount.

MPA for prescription medications at out-of-network pharmacies is no more than the prevailing pharmacy network fee based on the average wholesale price (AWP) accessed by Moda Health minus a percentage discount. Reimbursement for medications dispensed by all other providers will be subject to benefit provisions of the Plan and paid based on the lesser of either contracted rates, AWP or billed charges.

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

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

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

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

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

Medically necessary care does not include custodial care.

The fact that a provider prescribes, orders, recommends, or approves a service or supply does not, of itself, make the service medically necessary or a covered service. More information regarding medical necessity can be found in General Exclusions (Section 7).

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

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

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

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

Moda Health refers to Moda Health Plan, Inc.

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

Network means a group of providers who contract to provide healthcare to members. Such groups are called Preferred Provider Organizations (PPOs), and provide in-network services in their specific service areas. Covered medical expenses will be paid at a higher rate when an in-network provider is used (see section 2.2).

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

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

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

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

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

Prior Authorization or **Prior Authorized** refers to obtaining approval by Moda Health prior to the date of service. A complete list of services and medications that require prior authorization is available on myModa or by contacting Customer Service. Failure to obtain required authorization may result in denial of benefits or a penalty (see section 3.1).

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

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

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

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

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

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

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

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

SECTION 6. BENEFIT DESCRIPTION

The Plan covers services and supplies listed when medically necessary for diagnosis and/or treatment of a medical condition, as well as certain preventive services. Payment of covered expenses is always limited to the maximum plan allowance. Some benefits have day or dollar limits, which are noted in the "Details" column in the Schedule of Benefits (section 2.2).

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

6.1 MEMBERSHIP CARD

After enrollment, members will receive identification cards that will 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 identification card.

6.2 WHEN BENEFITS ARE AVAILABLE

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

a. Is eligible to be covered according to the eligibility provisions of the Plan
b. Has applied for coverage and has been accepted
c. Has had his or her premiums for the current month paid by the Group on a timely basis

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

6.3 EMERGENCY CARE

Members are covered for treatment of emergency medical conditions worldwide. A member who believes he or she has a medical emergency should call 911 or seek care from the nearest appropriate provider, such as a physician's office or clinic, urgent care facility or emergency room. All emergency room services will be reimbursed at the in-network benefit level. However, out-of-network providers may bill members for charges in excess of the maximum plan allowance. 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 services, including emergency medical screening exams or treatment to stabilize an emergency medical condition, when a prudent layperson possessing an average knowledge of health and medicine would reasonably believe that the failure to receive immediate medical attention would place the health of the member, or a fetus in the case of a pregnant woman, in serious jeopardy.

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

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

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

6.4 HOSPITAL & RESIDENTIAL FACILITY CARE

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

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

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

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

6.4.1 Emergency Room Care

Medically necessary emergency room care is covered. See section 6.3 for more information.

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

6.4.2 Pre-admission Testing

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

6.4.3 Hospital Benefits

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

a. **Hospital room.** The actual daily charge
b. **Isolation care.** When the Plan agrees it is necessary to protect other patients from contagion or to protect a member from contracting the illness of another person
c. **Intensive care unit**. Whether a unit in a particular hospital qualifies as an intensive care unit is determined using generally recognized standards
d. **Facility charges.** For surgery performed in a hospital outpatient department

e. **Other hospital services and supplies.** Those necessary for treatment and ordinarily furnished by a hospital
f. **Routine nursery care.** Including one in-nursery physician's visit of a well newborn infant while the mother is confined in the hospital and receiving maternity benefits under the Plan. The deductible is waived for routine nursery care.

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

6.4.4 Inpatient Rehabilitative and Habilitative Care

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

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

6.4.5 Skilled Nursing Facility Care

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

Covered 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 illness

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

6.4.6 Residential Mental Health and Chemical Dependency Treatment Programs

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

6.4.7 Chemical Dependency Detoxification Program

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

6.5 AMBULATORY SERVICES

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

6.5.1 Outpatient Surgery

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

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

6.5.2 Outpatient Rehabilitation and Habilitation

Rehabilitative services are physical, occupational, or speech therapies provided by a licensed physical, occupational or speech therapist, physician, chiropractor or other professional provider licensed to provide such services and are necessary to restore or improve lost function caused by a medical condition. A session is one visit. No more than one session of each type of physical, occupational, or speech therapy is covered in one day.

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

Habilitative physical, occupational or speech therapy is covered only when medically necessary for treatment of a mental health condition.

6.5.3 Infusion Therapy

The Plan covers infusion therapy services and supplies when prior authorized and ordered by a professional provider as a part of an infusion therapy regimen. See section 6.9.6 for self-administered infusion therapy.

Infusion therapy benefits are limited to the following:

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

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

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

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

6.5.5 Radium, Radioisotopic, X-ray Therapy, and Kidney Dialysis
Covered expenses include:

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

6.5.6 Imaging Procedures
The Plan covers all standard imaging procedures related to treatment of a medical condition. The following advanced imaging services require prior authorization:

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

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

6.5.8 Routine Costs in Clinical Trials
Routine costs for the care of a member who is enrolled in or participating in an approved clinical trial are covered. Routine costs mean medically necessary conventional care, items or services covered by the Plan if typically provided absent a clinical trial. Such costs will be subject to the applicable cost sharing if provided in the absence of a clinical trial. The Plan is not liable for any adverse effects of a clinical trial.

Approved clinical trials are limited to those:

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

The Plan does not cover items or services:

a. That are not covered by the Plan if provided outside of the clinical trial, including the drug, device or service being tested

b. Required solely for the provision or clinically appropriate monitoring of the drug device or service being tested in the clinical trial
c. Required solely for the prevention, diagnosis or treatment of complications arising from the provision of the drug, device or service being tested in the clinical trial
d. Provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the member
e. Customarily provided by a clinical trial sponsor free of charge to any person participating in the clinical trial

6.6 PROFESSIONAL PROVIDER SERVICES

6.6.1 Preventive Healthcare

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

a. Evidence-based services rated A or B by the United States Preventive Services Taskforce (www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/)
b. Immunizations recommended by the Advisory Committee on Immunization Practices of the Center for Disease Control and Prevention (ACIP)(www.cdc.gov/vaccines/acip/recs/)
c. Preventive care and screenings recommended by the Health Resources and Services Administration for infants, children, adolescents, and women (women's services: www.hrsa.gov/womensguidelines/)

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

Members may call Customer Service to verify if a preventive service is covered at no cost sharing. Other preventive services are subject to the applicable cost sharing when not prohibited by federal law.

Some frequently used preventive healthcare services covered by the Plan are:

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

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

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

    Routine diagnostic x-ray and lab work related to a periodic health exam are also covered and are subject to the standard cost sharing.

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

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

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

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

   Breast exams are limited to women 18 years of age and older. Mammograms are limited to one between the ages of 35 and 39, and one per year age 40 and older. Pap tests and breast exams, and mammograms for the purpose of diagnosis in symptomatic or designated high risk women, are also covered when deemed necessary by a professional provider. These services are covered under the office visit, x-ray or lab test benefit level if not performed for preventive purposes.

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

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

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

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

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

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

6.6.3 Diabetes Self-Management Programs

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

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

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

6.6.4 Therapeutic Injections

Administrative services for therapeutic injections, such as allergy shots, are covered when given in a professional provider's office. When comparable results can be obtained safely with home self-care or through oral use of a prescription drug, administrative services for therapeutic injections are not covered. (Additional information in section 6.8.1 and 6.9.6).

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

6.6.5 Surgery

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

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

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

6.6.7 Cosmetic and Reconstructive Surgery

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

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

Treatment for complications related to a surgery performed to correct a functional disorder is covered when medically necessary. Treatment for complications related to a surgery that does not correct a functional disorder is excluded.

Surgery for breast augmentation, achieving breast symmetry, and replacing breast implants (prosthetics) to accomplish an alteration in breast contour or size are not covered except as provided in section 6.6.6.

6.6.8 Cochlear Implants

Cochlear implants are covered when medically necessary and prior authorized.

6.6.9 Inborn Errors of Metabolism

The Plan covers treatment of inborn errors of metabolism that involve amino acid, carbohydrate and fat metabolism and for which standard methods of diagnosis, treatment and monitoring exist, including quantification of metabolites in blood, urine or spinal fluid, or enzyme or DNA confirmation in tissues. Coverage includes diagnosing, monitoring and controlling the disorders by nutritional and medical assessment, including but not limited to clinical visits, biochemical analysis and medical foods used in the treatment of such disorders.

6.6.10 Special Dental Care

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

a. The accidental injury must have been caused by a foreign object or was caused by acute trauma (e.g., a broken tooth resulting from biting and/or chewing is not an accidental injury)
b. Diagnosis is made within 6 months of the date of injury
c. Treatment is medically necessary and is provided by a physician or dentist while the member is enrolled in the Plan

The Plan only covers treatment within 12 months of the date of injury. Covered treatment is limited to that which will restore teeth to a functional state. Implants and implant related services under this provision are subject to a per member lifetime maximum. Exceptions to the timelines may be made when medically necessary.

6.6.11 Maxillofacial Prosthetic Services

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

6.6.12 Temporomandibular Joint Syndrome (TMJ)

TMJ related surgical procedures and splints require prior authorization, and are covered only when medically necessary as established by a history of arthritic degeneration documented in a

physician's medical record, or in cases involving severe acute trauma. Treatment of related dental diseases or injuries is excluded.

6.6.13 Applied Behavior Analysis

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

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

Coverage for applied behavior analysis does not include:

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

6.6.14 Mental Health

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

6.6.15 Child Abuse Medical Assessment

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

6.6.16 Podiatry Services

Covered for the diagnosis and treatment of a specific current problem. Routine podiatry services are not covered.

6.6.17 Tobacco Cessation

The Plan covers expenses incurred when a member age 10 or older participates in a tobacco cessation program. Covered expenses include counseling, office visits, medications and medical supplies provided or recommended by a tobacco cessation program or other professional provider.

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

6.6.18 Telemedical Health Services

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

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

6.6.19 Alternative Care

Alternative care is spinal manipulation, acupuncture services, and naturopathic substances. To be covered, alternative care must be within the scope of the professional provider's license. It also must not be specifically excluded under the Plan.

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

There is an aggregate annual maximum for alternative care services. Reimbursement and visit limits for other services, such as office visits, lab and diagnostic x-rays, and physical therapy services are under the Plan's standard benefit for the type of service provided. Office visits by chiropractors, acupuncturists and naturopaths are considered specialist office visits unless the provider is credentialed as a primary care provider.

6.7 OTHER SERVICES

6.7.1 Ambulance Transportation

Ambulance transportation, including local ground transportation by state certified ambulance and certified air ambulance transportation, is covered for medically necessary transport to the nearest facility that has the capability to provide the necessary treatment.

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

6.7.2 Hospice Care

a. Definitions

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

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

Hospice treatment plan means a written plan of care established and periodically reviewed by the member's attending physician. The physician must certify in the plan that the member

is terminally ill and the plan must describe the services and supplies for medically necessary or palliative care to be provided by the approved hospice.

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

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

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

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

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

The Plan covers respite care provided to a member who requires continuous assistance when arranged by the attending professional provider and prior authorized by Moda Health. The services and charges of a non-professional provider may be covered for respite care if approval is given by Moda Health in advance.

e. Exclusions
In addition to exclusions listed in Section 7, the following are not covered:

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

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

Home birth expenses are not covered other than the fees billed by a professional provider. Additional information regarding home birth exclusions is in Section 7. Supportive services, such as physical, emotional and informational support to the mother before, during and after birth and during the postpartum period, are not covered expenses.

Special Right Upon Childbirth (Newborns' and Mothers' Health Protection Act) Benefits for any hospital length of stay in connection with childbirth will not be restricted to less than 48 hours following a normal vaginal delivery or 96 hours following a cesarean section, unless the

mother's or newborn's attending professional provider, after consulting with the mother, chooses to discharge the mother or her newborn earlier. Prior authorization is not required for a length of stay up to these limits.

6.7.4 Breastfeeding Support

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

6.7.5 Transplants

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

a. Definitions

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

Transplant means a procedure or 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)
ii. tissue is removed from one's body and later reintroduced back into the body of the same person

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

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

i. If a transplant procedure is performed at a facility other than an exclusive transplant network facility, the deductible and coinsurance will not accumulate toward the out-of-pocket maximum amount. Note: Member coinsurance will apply to services not performed at an exclusive transplant network facility even if the member has met the out-of-pocket maximum.
ii. If the recipient or self-donor is enrolled in the Plan, donor costs related to a covered transplant, including expenses for an enrolled donor resulting from complications and unforeseen effects of the donation, are covered. If the donor is enrolled in the Plan and the recipient is not enrolled or is in the exclusion period, the Plan will not pay any benefits toward donor costs. Expenses incurred by a donor not enrolled in the Plan that result from complications and unforeseen effects of the donation are not covered. "Donor costs" means the covered expense of removing the tissue from the donor's body and preserving or transporting it to the site where the transplant is performed as well as any other necessary charges directly related to locating and procuring the organ.
iii. Professional provider transplant services are paid according to the benefits for professional providers.
iv. Immunosuppressive drugs provided during a hospital stay are paid as a medical supply. Outpatient oral and self-injectable prescription medications for transplant related services are paid under the Pharmacy Prescription Medication benefit (section 6.9).
v. The Plan will not pay for chemotherapy with autologous or homogenic/allogenic bone marrow transplant for treatment of any type of cancer not approved for coverage.

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

d. 24-Month Exclusion Period. Transplants will not be covered during the first 24 months a person is enrolled in the Plan. The 24-month exclusion period will not apply:

i. If the member has been continuously enrolled in the Plan since birth
ii. If the member was continuously enrolled in the Plan together with the Group's prior plan at least 24 months prior to incurring transplant related expenses. If the member had applicable coverage under a prior health benefit plan, each day of creditable coverage the member had under that prior health benefit plan will reduce the 24-month exclusion period by one day.

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

6.7.6 Biofeedback

Covered expenses for biofeedback therapy services are limited to treatment of tension or migraine headaches.

6.7.7 Home Healthcare

Home healthcare services and supplies are covered when provided by a home healthcare agency for a member who is homebound. ”Homebound” means that the member’s condition creates a general inability to leave home. If the member does leave home, the absences must be infrequent, of short duration, and mainly for receiving medical treatment. A home healthcare agency is a licensed public or private agency that specializes in providing skilled nursing and other therapeutic services, such as physical therapy, in a member’s home.

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

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

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

This benefit does not include home healthcare, home care services or supplies provided as part of a hospice treatment plan. These are covered under sections 6.7.2 and 6.7.8.

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

6.7.8 Supplies, Appliances and Durable Medical Equipment

Supplies

Includes:

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

Prosthetic and orthotic devices

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

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

Appliances

Items, including orthopedic braces, used for performing or facilitating the performance of a particular bodily function. Within 90 days following cataract surgery, one conventional intraocular lens or one contact lens or eyeglasses is covered for each eye operated on. However, the following are not covered: dental appliances and braces, supporting devices such as corsets, compression or therapeutic stockings except when such stockings are medically necessary, hearing aids except as stated in section 6.7.9, eye glasses and contact lenses except as otherwise covered by the Plan.

Orthopedic shoes

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

Durable medical equipment

Equipment and related supplies that are used primarily to serve a medical purpose, are not generally useful to a member in the absence of a medical condition, are appropriate for use in the member's home and are designed to withstand repeated use. Examples of durable medical equipment include a wheelchair, a hospital-type bed and oxygen.

The Plan covers the rental charge (not to exceed the purchase price) for durable medical equipment. Upon request, members must authorize any supplier furnishing durable medical equipment to provide information related to the equipment order and any other records Moda Health requires to approve a claim payment.

Replacement or repair

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

Exclusions
In addition to the exclusions listed in Section 7, the Plan will not cover the following appliances and equipment, even if they relate to a condition that is otherwise covered by the Plan:

a. Those used primarily for comfort, convenience, or cosmetic purposes
b. Wigs and toupees
c. Those used for education or environmental control (additional information regarding Supportive Environmental Materials can be found in Section 7)
d. Therapeutic devices, except for transcutaneous nerve stimulators
e. Incontinence supplies

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

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

Covered benefits include the following every 48 months:

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

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

6.8 MEDICATIONS

6.8.1 Medication Administered by Provider, Infusion Center or Home Infusion
A medication that is given by injection or infusion (intravenous administration) and is required to be administered in a professional provider's office, infusion center or home infusion is covered at the same benefit level as a supply. If the pharmaceutical is available in an oral dosage form, the Plan will not cover it in the form of an injectable medication unless it is medically necessary that the member use the injectable form. In addition, infusion and in-office injectables may require prior authorization by Moda Health or be subject to specific benefit limitations (more information is available on the Moda Health website). Self-administered medications are not covered under this benefit. See section 6.9.6. See section 6.9 for pharmacy benefits.

6.8.2 Anticancer Medication
Prescribed anticancer medications, including oral, intravenous (IV) or injected medications, are covered. Anticancer medications require prior authorization and may be subject to specific benefit limitations. Self-administered medications require delivery by an exclusive specialty pharmacy (see section 6.9.6). For some anticancer medications, members may be required to

enroll in programs to ensure proper medication use and/or reduce the cost of the medication. More information is available on myModa or by contacting Customer Service. See also sections 6.5.3 and 6.9.

6.9 PHARMACY PRESCRIPTION MEDICATION BENEFIT

Select, preferred and brand medication expenses are subject to a separate pharmacy deductible (see sections 2.2 and 2.3).

6.9.1 Definitions

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

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

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

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

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

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

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

Preferred Tier Medications. Preferred medications, including specialty preferred medications, have been reviewed by Moda Health and found to be clinically effective at a favorable cost when compared to other medications in the same therapeutic class and/or category. Generic medications that have been identified as having no more favorable outcomes, from a clinical perspective, than other more cost effective generic medications may be included in this tier.

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

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

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

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

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

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

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

6.9.2 Covered Expenses

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

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

6.9.3 Covered Medication Supply

A covered medication supply includes the following:

a. A legend medication that is medically necessary for treatment of a medical condition
b. Compounded medications containing at least one covered medication as the main ingredient
c. Insulin and diabetic supplies including insulin syringes, needles and lancets, glucometers and test strips, and glucose tablets when accompanied by a valid prescription
d. Select prescribed preventive medications required under the Affordable Care Act
e. Select immunizations and related administration fees are covered with no cost sharing at in-network retail pharmacies (e.g. influenza, pneumonia and shingles vaccines)

Certain prescription medications and/or quantities of prescription medications may require prior authorization (see section 3.1.3). For assistance coordinating prescription refills, contact Pharmacy Customer Service.

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

6.9.5 Specialty Services and Pharmacy
The pharmacist and other professional providers will advise a member if a prescription requires prior authorization or delivery by an exclusive specialty pharmacy. Specialty medications are often used to treat complex chronic health conditions. Because specialty treatments often require special handling techniques, careful administration and a unique ordering process, the Plan provides enhanced member services for these medications. Information about the clinical services and a list of eligible specialty medications is available on myModa or by contacting Customer Service. If a member does not purchase these medications at the exclusive specialty pharmacy, the expense will not be covered.

Specialty medications must be prior authorized. Some specialty prescriptions may have shorter day supply coverage limits. More information is available on myModa or by contacting Customer Service. For some specialty medications, members may be required to enroll in programs to ensure proper medication use and/or reduce the cost of the medication.

6.9.6 Self Administered Medication
All self-administered medications are subject to the pharmacy prescription medication requirements of section 6.9. Self-administered specialty medications are subject to the same requirements as other specialty medications (section 6.9.1). For some specialty medications, members may be required to enroll in programs to ensure patient safety, proper drug use and/or reduce the cost of the medication.

Self-administered injectable medications are not covered when administered in a provider's office, clinic or facility (e.g., as a supply).

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

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

a. In addition to those medications included in the current prior authorization list on myModa, prior authorization is required for
    i. Retail prescriptions with a net cost over $1,500 for a 30-day supply
    ii. Mail-order prescriptions with a net cost over $4,500
    iii. Specialty prescriptions with a net cost over $8,000
    iv. Compounded medications with a net cost over $150 for a 30-day supply
b. New FDA approved medications are subject to review and may be subject to additional coverage requirements or limits established by the Plan. A member or prescriber can request a medical necessity evaluation if a newly approved medication is initially denied during the review period.
c. If a brand medication is dispensed when a generic equivalent is available, the member may be responsible for the difference in cost between the generic and brand medication.

d. Coverage of weight-loss medications is subject to review and will be covered if medical necessity is determined for the medical treatment of weight-loss or obesity under the Plan.
e. Select specialty medications that have been determined to have a high discontinuation rate or short durations of use may be limited to a 15-day supply.
f. Medications with dosing intervals beyond the Plan's maximum day supply will be assessed an increased copayment consistent with the day supply. This includes a 12-month supply of contraceptives when permitted by law
g. Claims for medications purchased outside of the United States and its territories will only be covered in emergency and urgent care situations.
h. Early refill of medications for travel outside of the United States is subject to review, and when allowed is limited to once every 6 months.

6.9.9 Exclusions

In addition to the exclusions listed in Section 7, the following medication supplies are not covered:

a. **Devices.** Including, but not limited to therapeutic devices and appliances. Information for contraceptive devices is in section 6.9.3 and for other devices in section 6.7.8
b. **Experimental or Investigational Medications.** Including any medication used for an experimental or investigational purpose, even if it is otherwise approved by the federal government or recognized as neither experimental nor investigative for other uses or health conditions
c. **Foreign Medication Claims.** Medications purchased from non-U.S. mail order or online pharmacies or U.S. mail or online pharmacies acting as agents of non-U.S. pharmacies
d. **Hair Growth Medications.**
e. **Immunization Agents for Travel.**
f. **Institutional Medications.** To be taken by or administered to a member in whole or in part while the member is a patient in a hospital, sanitarium, rest home, skilled nursing facility, extended care facility, nursing home or similar institution
g. **Medication Administration.** A charge for administration or injection of a medication, except for select immunizations at in-network 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 Resources Commission
m. **Over the Counter (OTC) Medications** and prescription medications for which there is an OTC equivalent or alternative
n. **Repackaged Medications.**
o. **Replacement Medications and/or Supplies.**
p. **Weight Loss Medications.**

6.9.10 Choice 90 Program

Choice 90 is a program that allows members to purchase a 90-day supply from a participating Choice 90 retail pharmacy. Certain 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 7. GENERAL EXCLUSIONS

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

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 6.6.6) and complications of reconstructive surgeries if medically necessary and not specifically excluded.

Court Ordered Sex Offender Treatment

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

Dental Examinations and Treatment; Orthodontia
Except as specifically provided for in sections 6.6.10 and 6.6.11, or if medically necessary to restore function due to craniofacial anomaly

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

Experimental or Investigational Procedures
Including expenses incidental to or incurred as a direct consequence of such procedures

Faith Healing

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

Financial Counseling Services

Food Services
"Meals on Wheels" and similar programs

Guest Meals in a Hospital or Skilled Nursing Facility

Hearing Aids
Except as specifically provided for in section 6.7.9

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

Homemaker or Housekeeping Services

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

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

Inmates
Services and supplies a member receives while in the custody of any state or federal law enforcement authorities or while in jail or prison, except when pending disposition of charges. Benefits paid under this exception may be limited to 115% of the Medicare allowable amount.

Legal Counseling

Massage or Massage Therapy

Mental Examination and Psychological Testing and Evaluations
For the purpose of adjudication of legal rights, administrative awards or benefits, corrections or social service placement, employment, or any use except as a diagnostic tool for the treatment of mental illness or as specifically provided for in section 6.6.15

Missed Appointments

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

Never Events
Services and supplies related to never events, which are events that should never happen while receiving services in a hospital or facility including the wrong surgery, surgery on the wrong body part, or surgery on the wrong patient. These also apply to any hospital acquired condition, as that term is defined in the Centers for Medicare and Medicaid Services (CMS) guidelines, which includes serious preventable events.

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

Nutritional Counseling

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

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

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

Orthopedic Shoes
Except as provided for in section 6.7.8

Orthognathic Surgery
Including associated services and supplies

Pastoral and Spiritual Counseling

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

Physical Exercise Programs

Private Nursing Services

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

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

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

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

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

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

Self Administered Medications
Including oral and self injectable when provided directly by a physician's office, facility or clinic instead of through the prescription medication or anticancer benefits (sections 6.9.6 and 6.8.2).

Self Help Programs

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

Services Otherwise Available
Including those services or supplies:

a. for which payment could be obtained in whole or in part if a member had applied for payment under any city, county, state or federal law, except for Medicaid coverage
b. for which a member cannot be held liable because of an agreement between the provider and another third party payer which has paid or is obligated to pay for such service or supply
c. for which no charge is made, or for which no charge is normally made in the absence of insurance
d. 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 Dysfunctions of Organic Origin
Services for sexual dysfunctions of organic origin, including impotence and decreased libido. This exclusion does not extend to sexual dysfunction diagnoses listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders.

Support Education
Including:

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

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

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

Taxes

Telemedical Health Services
Including telephone visits or consultations and telephone psychotherapy, except as specifically provided for in section 6.6.18

Telephones and Televisions in a Hospital or Skilled Nursing Facility

Therapies
Services or supplies related to, hippotherapy, and maintenance therapy and programs.

Third Party Liability Claims
Services and supplies for treatment of a medical condition for which a third party is or may be responsible, to the extent of any recovery received from or on behalf of the third party (see section 10.4.2)

Transportation
Except medically necessary ambulance transport

Treatment in the Absence of Illness
Including individual or family counseling or treatment for marital, behavioral, financial, family, occupational or religious problems, treatment for “at risk” individuals in the absence of illness, or treatment of “normal” transitional response to stress

Treatment After Coverage Terminates
The only exception is if a member is hospitalized at the time the Plan terminates (see section 6.2), 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. For example, coverage is not allowed for an inpatient hospital stay or residential chemical dependency treatment program when an appropriate level of treatment could be delivered in an outpatient setting such as an ambulatory surgery facility or outpatient chemical dependency treatment program

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

Treatment Prior to Enrollment
Including services and supplies for an admission to a hospital, skilled nursing facility or other facility that began before the member's coverage under the Plan began. Reimbursement for such admission will be the responsibility of the plan under which the member was covered immediately preceding and extending up to the effective date of the Plan. If no such plan was in effect, Moda Health will provide coverage only for those covered expenses incurred on or after the member's effective date under the Plan.

Vision Care
Including eye exams, the fitting, provision, or replacement of eyeglasses or contact lenses, and any charges for orthoptics, vitamin therapy, low vision therapy, eye exercises or fundus photography, except as otherwise provided under the Plan.

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

Wigs, Toupees, Hair Transplants

Work Related Conditions
Treatment of a medical condition arising out of or in the course of employment or self-employment for wages or profit, unless the expense is denied under any workers' compensation provision. This exclusion does not apply to owners, partners or executive officers if they are exempt from workers' compensation laws and the Group does not provide workers' compensation coverage to them.

SECTION 8. ELIGIBILITY

The date a person becomes eligible may be different than the date coverage begins (see Section 9).

8.1 SUBSCRIBER

A person is eligible to enroll in the Plan if he or she:

a. is a permanent documented full time or part time employee, sole proprietor, owner, business partner or corporate officer of the Group
b. is not a leased substitute, or temporary employee, or an agent, consultant or independent contractor. A seasonal employee is not eligible unless defined as a full-time employee under the terms of the Affordable Care Act
c. is paid on a regular basis through the payroll system, has federal taxes deducted from such pay, and is reported to Social Security
d. works for the Group on a regularly scheduled basis at least 30 hours per week
e. satisfies any orientation and/or eligibility waiting period

Subscribers are eligible to remain enrolled if they are on an approved leave of absence under state or federal family and medical leave laws.

8.2 DEPENDENTS

A subscriber's legal spouse or domestic partner is eligible for coverage. A subscriber's children are eligible until their 26th birthday. Children eligible due to a court or administrative order are subject to the Plan's child age limit.

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

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

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

a. Recent medical or psychiatric progress notes and evaluations, referrals or consult notes
b. Relevant test results (e.g., lab, imaging, neuro-psychiatric testing, etc.)

c. Relevant recent hospitalization records (e.g., history and physical, discharge summary)
d. Disability information from prior carrier

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

8.3 QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

The Plan will cover a child of an eligible employee who has a right to enrollment due to a qualified medical child support order (QMCSO). The Plan has detailed procedures for determining whether an order qualifies as a QMCSO. A copy of such procedures is available from the Group without charge.

The child's coverage under the Plan will be effective as of the first day of the month following the date that the Group determines that applicable order qualifies as a QMCSO and that the child is eligible for enrollment in the Plan.

8.4 NEW DEPENDENTS

If a subscriber marries or registers a domestic partnership, the spouse or domestic partner and his or her children are eligible to enroll as of the date of the marriage or registration. If a subscriber files an Affidavit of Domestic Partnership with the Group, the unregistered domestic partner and his or her children are eligible for coverage.

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

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

8.5 ELIGIBILITY AUDIT

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

SECTION 9. ENROLLMENT

9.1 ENROLLING ELIGIBLE EMPLOYEES

A complete and signed application for the eligible employee or retiree and any dependents to be enrolled must be filed with the Group within 31 days of becoming eligible to apply for coverage. Eligible employees can apply on the date of hire or the end of any required waiting period.

The subscriber must notify the Group and Moda Health of any change of address.

9.2 ENROLLING NEW DEPENDENTS

To enroll a new dependent, a complete and signed application and, when applicable, a marriage certificate, domestic partnership documentation or adoption or placement for adoption paperwork must be submitted within 31 days of their eligibility. The subscriber must notify Moda Health if family members are added or dropped from coverage, even if it does not affect premiums.

9.3 OPEN ENROLLMENT

If an eligible employee and/or any eligible dependents are not enrolled within 31 days of first becoming eligible, they must wait for the next open enrollment period to enroll unless:

a. The person qualifies for special enrollment as described in section 9.4
b. A court has ordered that coverage be provided for a spouse or minor child under a subscriber's health benefit plan and request for enrollment is made within 30 days after issuance of the court order
c. The person's coverage under Medicaid, Medicare, Tricare, Indian Health Service or a publicly sponsored or subsidized health plan, including but not limited to the Oregon Health Plan, has been involuntarily terminated within 63 days prior to applying for coverage in a group health benefit plan

Open enrollment occurs once a year at renewal.

At the time of retirement or any day thereafter, if a retiree declines or drops coverage for the retiree and/or dependents, that decision is irrevocable. Open enrollment is not available for retiree coverage.

9.4 SPECIAL ENROLLMENT RIGHTS

The special enrollment rights as described in sections 9.4.1 and 9.4.2 apply:

a. To an eligible employee who loses other coverage or becomes eligible for a premium assistance subsidy
b. To a subscriber's dependent who loses other coverage or becomes eligible for a premium assistance subsidy

c. To both the eligible employee and his or her dependent if neither is enrolled in the Plan, and either loses other coverage or becomes eligible for a premium assistance subsidy

To enroll, an eligible employee must submit a complete and signed application within the required timeframe.

9.4.1 Loss of Other Coverage

If coverage is declined when initially eligible because of other health coverage, an eligible employee or any dependents may enroll in the Plan outside of the open enrollment period if the following criteria are met:

a. He or she was covered under a group health plan or had health insurance coverage at the time coverage was previously offered
b. He or she stated in writing at such time that coverage under a group health plan or health insurance coverage was the reason enrollment was declined
c. He or she requests such enrollment not later than 31 days after the previous coverage ended (except for event iv. below, which allows up to 60 days)
d. One of the following events has occurred:
    i. His or her prior coverage was under a COBRA continuation provision and the coverage under such provision was exhausted
    ii. His or her prior coverage was terminated as a result of loss of eligibility for the coverage. Examples of when coverage under a plan may be lost include:
        A. legal separation or divorce
        B. loss of dependent status per plan terms
        C. death
        D. termination of employment
        E. reduction in the number of hours of employment
        F. the plan ceasing to offer coverage to a group of similarly situated persons
        G. moving out of an HMO service area that results in termination of coverage and no other option is available under the plan
        H. termination of the benefit package option, and no substitute option is offered
    iii. The employer contributions toward his or her other coverage were terminated. (If employer contributions cease, the eligible employee or dependent does not have to terminate coverage under the prior plan in order to be eligible for special enrollment.)
    iv. His or her prior coverage was under Medicaid or a children's health insurance program (CHIP) and such coverage was terminated due to loss of eligibility. Special enrollment must be requested within 60 days of the termination.

9.4.2 Eligibility for Premium Subsidy

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.

9.4.3 New Dependents

An eligible employee, spouse or domestic partner and children will have special enrollment rights if they are not enrolled at the time of the event that caused the eligible employee to gain a new dependent (e.g., marriage, domestic partnership, birth, adoption, or placement for adoption).

9.5 WHEN COVERAGE BEGINS

Coverage for subscribers begins on the enrollment date or after a waiting period, as specified in the policy.

Coverage for new dependents through marriage, registration of a domestic partnership, or the filing of an Affidavit of Domestic Partnership with the Group begins on the date of marriage, registration, or filing.

Coverage for a newborn is effective on the date of the newborn's birth. Coverage for a child newly adopted or placed for adoption is effective on the date of adoption or placement. Court ordered coverage is effective on the first day of the month following the date the Group determines that an applicable order qualifies as a QMCSO and that the child is eligible for enrollment in the Plan.

Coverage for those enrolling during open enrollment begins on the date the Plan renews. All other plan provisions will apply. Coverage under special enrollment due to loss of coverage or eligibility for premium subsidy begins on the first day of the month following receipt of the special enrollment request, or coinciding with, but not before the loss of other coverage.

The necessary premiums must also be paid for coverage to become effective.

9.6 WHEN COVERAGE ENDS

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

9.6.1 Group Plan Termination

Coverage ends for the Group and members on the date the Plan ends. There is one exception to this rule. If the Group terminates the Plan and a member is hospitalized on the day the Plan ends, coverage under the Plan shall continue until the hospital confinement ends.

If the policy is terminated and coverage is not replaced by the Group, Moda Health will notify the Group of the termination within 10 business days. The notice will explain members' rights to continuation coverage under federal and/or state law. It is the Group's responsibility to provide this information to members.

9.6.2 Termination by Subscriber

A subscriber may terminate his or her coverage, or coverage for any enrolled dependent, by giving Moda Health written notice through the Group, unless the coverage election is considered irrevocable for the plan year (such as when the employee's share of the premium is withheld from his or her paycheck on a pretax basis). Coverage ends on the last day of the month through which premiums are paid.

9.6.3 Death

If a subscriber dies, coverage for any enrolled dependents ends on the last day of the month in which the death occurs. Enrolled dependents may extend their coverage for up to 3 years if the requirements for continuation of coverage are met (see Section 13). The Group must notify Moda Health of any continuation of coverage, and appropriate premiums must be paid along with the Group's regular monthly payment.

9.6.4 Termination, Layoff or Reduction in Hours of Employment

Coverage ends on the last day of the month in which employment ends, unless a member chooses to continue coverage (see Section 13).

If a subscriber is laid off and returns to active work within 6 months of being laid off, he or she and any eligible dependents may enroll in the Plan on the date of rehire and coverage will begin on that date.

If a subscriber experiences a reduction in hours that causes loss of coverage, and within 6 months the hours increase and the subscriber again qualifies for benefits, he or she and any eligible dependents may enroll in the Plan on the date the subscriber qualifies and coverage will begin on that date.

All plan provisions will resume at re-enrollment whether or not there was a lapse in coverage. The period of layoff or reduction in hours will be counted toward any exclusion period. Upon re-enrollment in the Plan, any waiting period required by the Plan will not have to be re-served.

The Group must notify Moda Health that the subscriber has been rehired following a layoff or that the subscriber's hours have been increased, and the necessary premiums for coverage must be paid.

9.6.5 Loss of Eligibility by Retirees

Coverage ends for a retiree on the last day of the month in which the retiree turns 65.

9.6.6 Loss of Eligibility by Dependent

Coverage ends for an enrolled spouse on the last day of the month in which a decree of divorce or annulment is entered (regardless of any appeal), and for an enrolled domestic partner on the last day of the month in which a judgment of dissolution or annulment of the domestic partnership has been entered or that a partnership no longer meets the requirements of the Affidavit of Domestic Partnership. Coverage ends for an enrolled child on the last day of the month in which the child reaches age 26.

Enrolled dependents may have the right to continue coverage in their own names when their coverage under the Plan ends.

9.6.7 Rescission

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

9.6.8 Continuing Coverage

Information is in Continuation of Health Coverage (Section 13).

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.

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

10.1.1 Hospital and Professional Provider Claims

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

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

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

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

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

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

10.1.2 Ambulance Claims

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

10.1.3 Tobacco Cessation Program Claims

Moda Health will be billed directly by the tobacco cessation program for the cost of counseling, consultation and supplies. Other providers may require a member to pay the charges and submit the claim to Moda Health. If this happens, the member should submit a request for reimbursement. Prescription tobacco medications follow the process in section 10.1.4. Members should use the claim form specific to the tobacco cessation program for over the

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

10.1.4 Prescription Medication Claims

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

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

10.1.5 Explanation of Benefits (EOB)

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

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

10.1.6 Claim Inquiries

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

10.2 COMPLAINTS, APPEALS AND EXTERNAL REVIEW

10.2.1 Definitions

For purposes of section 10.2, the following definitions apply:

Adverse Benefit Determination means a written notice from Moda Health, in the form of a letter or an Explanation of Benefits (EOB), of any of the following: rescission of coverage, or a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including one based on a determination of a person's eligibility to participate in the Plan and one resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not necessary and customary by the standards of generally accepted practice for the prevention or treatment of disease or accidental injury, or when continuity of care is denied because the course of treatment is not considered active. A **Final Internal Adverse Benefit Determination** is an adverse benefit determination that has been upheld by Moda Health at the completion of the internal appeal process or with respect to which the internal appeal process has been exhausted.

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

Claim Involving Urgent Care means any claim for medical care or treatment in which the application of the regular time period to review a denial of a pre-service claim could seriously jeopardize a member's life or health or ability to regain maximum function, or, in the opinion

of a physician with knowledge of a member's medical condition, would subject the member to severe pain that cannot be adequately managed without the requested care or treatment.

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

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

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

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

10.2.2 Time Limit for Submitting Appeals

A member has **180 days** from the date of an adverse benefit determination to submit an initial written appeal. If an appeal is not submitted within the timeframes outlined in this section, the rights to the appeals process will be lost.

10.2.3 The Review Process

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

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

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

The member may review the claim file and present evidence and testimony as part of the appeal process, and may appoint a representative to act on his or her behalf.

10.2.4 First Level Appeals

Before filing an appeal, it may be possible to resolve a dispute with a phone call to Customer Service. Otherwise, an appeal must be submitted in writing. If necessary, Customer Service can provide assistance filing an appeal. Moda Health will acknowledge receipt of the written appeal within 7 days and conduct an investigation by persons who were not involved in the original determination.

Appeals related to an urgent care claim will be entitled to expedited review upon request. Expedited reviews will be completed within 72 hours in total for the first and second level appeals combined after receipt of those appeals by Moda Health, not counting the lapse between the first level appeal determination and receipt of the second level appeal by Moda Health. If the member fails to provide sufficient information for Moda Health to make a decision at each appeal level, Moda Health will notify the member within 24 hours of receipt of the appeal of the specific information necessary to make a decision. The member must provide the specified information as soon as possible.

When an investigation has been completed, Moda Health will send a written notice of the decision to the member, including the basis for the decision, and if applicable, information on the right to a second level appeal. This notice will be sent within 15 days of a pre-service appeal or 30 days of a post-service appeal.

10.2.5 Second Level Appeals

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

Investigations and responses to a second level appeal will be by persons who were not involved in the initial determinations, and will follow the same timelines as those for a first level appeal. If new or additional evidence or rationale is used by Moda Health in connection with the claim, it will be provided to the member, in advance and free of charge, before any final internal adverse benefit determination. Members may respond to this information before Moda Health's determination is finalized. Moda Health will send a written notice of the decision to the member, including the basis for the decision, and if applicable, information on the right to file a lawsuit under ERISA Section 502(a) and the right to request an external review.

10.2.6 External Review

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

a. The dispute must relate to an adverse determination based on a utilization review decision; whether a course or plan of treatment that a member is undergoing is an active course of treatment for purposes of continuity of care (see section 10.3); or cases in which Moda Health fails to meet the internal timeline for review or the federal requirements for providing related information and notices.
b. The request for external review must be in writing no more than 180 days after receipt of the final internal adverse benefit determination. A member may submit additional information to the independent review organization within 5 days, or 24 hours for an expedited review.
c. The member must sign a waiver granting the independent review organization access to his or her medical records.
d. The member must have exhausted the appeal process described in sections 0 and 10.2.5. However, Moda Health may waive this requirement and have a dispute referred directly to external review with the member's consent. For an urgent care claim or when

the dispute concerns a condition for which a member received emergency services and is still hospitalized, a request for external review may be expedited or simultaneous with a request for internal appeal review.

e. The member shall provide complete and accurate information to the independent review organization in a timely manner.

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

A final internal adverse benefit determination based on specific exclusions or limitations on the amount, duration, or scope of coverage that does not involve medical judgment or a decision on whether a person is a member under the Plan does not qualify for external review. A complaint decision does not qualify for external review.

10.2.7 Complaints

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

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

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

10.2.8 Additional Member Rights

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

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

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

10.3 CONTINUITY OF CARE

10.3.1 Continuity of Care

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

Moda Health will provide continuity of care if a medical services contract or other contract for a professional provider's services is terminated, the provider no longer participates in the network, and the Plan does not cover services when services are provided to members by the

professional provider or covers services at a benefit level below the benefit level specified in the Plan for out-of-network professional providers.

Continuity of care requires the professional provider to be willing to adhere to the medical services contract that had most recently been in effect between the professional provider and Moda Health, and to accept the contractual reimbursement rate applicable at the time of contract termination, or if the contractual reimbursement rate was not based on a fee for service, a rate equivalent to the contractual rate.

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

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

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

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

Moda Health will not provide continuity of care if the member leaves the Plan or if the Group discontinues the Plan in which the member is enrolled.

10.3.2 Length of Continuity of Care

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

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

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

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

10.3.3 Notice Requirement

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

termination of the contractual relationship takes effect or no later than the 10th day after Moda Health first learns the identity of an affected member after the date of termination of the contractual relationship. If the professional provider belongs to a provider group, the provider group may deliver the notice if the notice clearly provides the information that the Plan is required to provide to the affected members.

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

10.4 BENEFITS AVAILABLE FROM OTHER SOURCES

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

10.4.1 Coordination of Benefits (COB)

This provision applies when a member has healthcare coverage under more than one plan. A complete explanation of COB is in Section 11.

10.4.2 Third Party Liability

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

The member agrees that Moda Health has the rights described in section 10.4.2. Moda Health may seek recovery under one or more of the procedures outlined in this section. The member agrees to do whatever is necessary to fully secure and protect, and to do nothing to prejudice, Moda Health's right of recovery or subrogation as discussed in this section. Moda Health has discretion to interpret and construe these recovery and subrogation provisions.

10.4.2.1 Definitions

For purposes of section 10.4.2, the following definitions apply:

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

Recovery Funds means any amount recovered from a third party.

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

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

10.4.2.2 Subrogation

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

10.4.2.3 Right of Recovery

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

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

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

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

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

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

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

10.4.2.5 Additional Provisions

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

a. The member shall cooperate with Moda Health to protect its recovery rights, including by:
    i. Signing and delivering any documents Moda Health reasonably requires to protect its rights, including a Third Party Reimbursement Questionnaire and Agreement. If the member has retained an attorney, then the attorney must also sign the agreement. The Plan will not be required to pay benefits until the agreement is properly signed and returned.
    ii. Providing any information to Moda Health relevant to the application of the provisions of section 10.4.2, including all information available to the member, or any representative or attorney representing the member, relating to the potential third party claim. This may include medical information, settlement correspondence, copies of pleadings or demands, and settlement agreements, releases or judgments
    iii. Notifying Moda Health of the potential third party claim for which the Plan may issue benefits. The member has this responsibility even if the first request for payment of benefits is a bill or invoice submitted to Moda Health by the member's provider
    iv. Taking such actions as Moda Health may reasonably request to assist it in enforcing its third party recovery rights

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

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

d. The member agrees that Moda Health may notify any third party, or third party's representatives or insurers, of its recovery rights described in section 10.4.2.

e. Even without the member's written authorization, Moda Health may release to, or obtain from, any other insurer, organization or person, any information it needs to carry out the provisions of section 10.4.2.

f. Section 10.4.2 applies to any member for whom advance payment of benefits is made by Moda Health whether or not the event giving rise to the member's injuries occurred before the member became covered by Moda Health.

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

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

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

10.5 MEDICARE

The Plan coordinates benefits with Medicare Part A and B as required under federal government rules and regulations. To the extent permitted by law, the Plan will not pay for any part of a covered expense to the extent the expense is actually paid or would have been paid under Medicare Part A or B had the member properly enrolled in Medicare and applied for benefits. The Plan will estimate what Medicare would have paid and reduce its benefits based on the estimate.

In addition, if the Plan is secondary to Medicare, Moda Health will not pay for any part of expenses incurred from providers who have opted out of Medicare participation.

SECTION 11. COORDINATION OF BENEFITS

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

11.1 DEFINITIONS

For purposes of section 11, the following definitions apply:

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

Plan includes:

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

Plan does not include:

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

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

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

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

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

Allowable expense means a healthcare expense, including cost sharing, that is covered at least in part by any plan covering the member. When a plan provides benefits in the form of a service rather than cash payments, the reasonable cash value of the service will also be considered an

allowable expense and a benefit paid. An expense that is not covered by any plan covering the member is not an allowable expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a member is not an allowable expense.

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

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

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

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

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

11.2 HOW COB WORKS

If the member is covered by another plan or plans, the benefits under this Plan and the other plan(s) will be coordinated. This means one plan pays its full benefits first, and then any other plans pay. The order of benefit determination rules govern the order in which each plan will pay a claim for benefits.

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

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

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

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

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

The first of the following rules that applies will govern:

a. **Non-dependent/Dependent.** If a plan covers the member as other than a dependent, for example, an employee, member of an organization, primary insured, or retiree, then that plan will determine its benefits before a plan that covers the member as a dependent. However, if the member is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the member as a dependent and primary to the plan covering the member as other than a dependent (e.g. a retired employee), then the order of benefits between the 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, the length of coverage provision below shall determine the order of benefits. If coverage under either or both parents' plans and the spouse's plan began on the same day, the birthday rule will apply.
f. **Active/Retired or Laid Off Employee.** The plan that covers a member as an active employee, that is, one who is neither laid off nor retired (or as that employee's dependent) determines its benefits before those of a plan that covers the member as a laid off or retired employee (or as that employee's dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of the benefits, this rule is ignored.
g. **COBRA or State Continuation Coverage.** If a member whose coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the member as an employee, member of an organization, primary insured, or retiree or as a dependent of the same, is the primary plan and the COBRA or other continuation coverage is the secondary plan. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of the benefits, this rule is ignored.
h. **Longer/Shorter Length of Coverage.** The plan that covered a member longer is the primary plan and the plan that covered the member for the shorter period of time is the secondary plan.
i. **None of the Above.** If the preceding rules do not determine the order of benefits, the allowable expenses shall be shared equally between the plans. In addition, this Plan will not pay more than it would have paid had it been the primary plan.

11.4 EFFECT ON THE BENEFITS OF THIS PLAN

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

If the primary plan is a closed panel plan and the member uses an out-of-network provider, the

secondary plan shall provide benefits as if it were the primary plan, except for emergency services or authorized referrals that are paid or provided by the primary plan.

11.5 PHARMACY COB

Claims subject to the COB provision of the Plan may be submitted electronically by pharmacies or through the direct member reimbursement paper claim process. The preferred method is for the pharmacy to electronically transmit the primary plan's remaining balance to Moda Health for processing. If approved, the secondary claim will be automatically processed according to plan benefits. Members who are unable to have their secondary claims processed electronically may submit a claim reimbursement request directly to Moda Health (see section 10.1.4).

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

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

Approved by Primary:

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

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

SECTION 12. MISCELLANEOUS PROVISIONS

12.1 RIGHT TO COLLECT AND RELEASE NEEDED INFORMATION

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

12.2 CONFIDENTIALITY OF MEMBER INFORMATION

Keeping a member's protected health information confidential is very important to Moda Health. Protected health information includes enrollment, claims, and medical and dental information. Moda Health uses such information internally for claims payment, referrals and authorization of services, and business operations such as case management and quality management programs. Moda Health does not sell this information. The Notice of Privacy Practices provides more detail about how Moda Health uses members' information. A copy of the notice is available on the Moda Health website by following the HIPAA link or by calling 503-243-4492.

12.3 TRANSFER OF BENEFITS

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

12.4 RECOVERY OF BENEFITS PAID BY MISTAKE

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

12.5 CORRECTION OF PAYMENTS

If benefits that this Plan should have paid are instead paid by another plan, this Plan may reimburse the other plan. Amounts reimbursed are plan benefits and are treated like other plan benefits in satisfying the Plan's liability.

12.6 CONTRACT PROVISIONS

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

12.7 REPLACING ANOTHER PLAN

For persons covered on an earlier Moda Health or other group plan that this Plan replaces, provided they remain eligible for coverage according to the requirements of the Plan, Moda Health will apply the benefits under the Plan reduced by any benefits payable by the prior plan. This replacement provision does not apply to any person excluded from coverage under the Plan because the person is otherwise covered under another policy with similar benefits. The Plan shall give credit for the satisfaction or partial satisfaction of any deductibles met under the prior plan for the same or overlapping benefit periods with the Plan, but the credit shall apply or be given only to the extent that the expenses are recognized under the terms of the Plan and are subject to a similar deductible provision.

12.8 RESPONSIBILITY FOR QUALITY OF MEDICAL CARE

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

12.9 WARRANTIES

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

12.10 NO WAIVER

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

12.11 GROUP IS THE AGENT

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

12.12 COMPLIANCE WITH FEDERAL AND STATE MANDATES

Moda Health provides benefits in accordance with the requirements of all applicable state and federal laws and as described in the Plan. This includes compliance with federal mental health parity requirements.

12.13 GOVERNING LAW

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

12.14 WHERE ANY LEGAL ACTION MUST BE FILED

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

12.15 TIME LIMITS FOR FILING A LAWSUIT

Any legal action arising out of, or related to, the Plan and filed against Moda Health by a member or any third party, must be filed in court no more than 3 years after the time the claim was filed (see section 10.1). All internal levels of appeal under the Plan must be exhausted before filing a legal action in court.

12.16 EVALUATION OF NEW TECHNOLOGY

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

SECTION 13. CONTINUATION OF HEALTH COVERAGE

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

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

13.1.1 Introduction

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

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

Note: In section 13.1 the term "domestic partner" refers only to a registered domestic partner, as defined in Section 5.

13.1.2 Eligibility

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

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

13.1.3 Notice and Election Requirements

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

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

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

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

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

13.1.4 Premiums

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

13.1.5 When Coverage Ends

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

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

13.2 COBRA CONTINUATION COVERAGE

13.2.1 Introduction

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

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

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

13.2.2 Qualifying Events

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

Spouse. The spouse of a subscriber has the right to continuation coverage if coverage is lost for

any of the following qualifying events:

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

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

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

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

Domestic Partners. A subscriber, who at the time of the qualifying event was covering his or her domestic partner under the Plan, can elect COBRA continuation coverage that includes continuing coverage for the domestic partner. A domestic partner who is covered under the Plan by the subscriber is not an eligible member and, therefore, does not have an independent election right under COBRA. This also means that the domestic partner's coverage ceases immediately when the subscriber's COBRA coverage terminates (for example, due to the subscriber's death or because the subscriber becomes covered under another plan).

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

13.2.3 Other Coverage

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

13.2.4 Notice and Election Requirements

Qualifying Event Notice. A dependent member's coverage terminates as of the last day of the month in which a divorce or legal separation occurs (spouse's coverage is lost) or a child loses dependent status under the Plan (child loses coverage). Under COBRA, the subscriber or a family member has the responsibility to notify the COBRA Administrator if one of these events occurs by mailing or hand-delivering a written notice to the COBRA Administrator. The notice must include the following: 1) the name of the Group; 2) the name and social security number of the affected members; 3) the event (e.g. divorce): and 4) the date the event occurred. Notice must be given no later than 60 days after the loss of coverage under the Plan. If notice of the event is not given on time, continuation coverage will not be available.

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

Otherwise, members will be notified by the COBRA Administrator of the right to elect COBRA continuation coverage within 44 days of any of the following events that result in a loss of coverage: the subscriber's termination of employment (other than for gross misconduct) or 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 insurance coverage will end.

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

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

13.2.5 COBRA Premiums

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

13.2.6 Length of Continuation Coverage

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

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

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

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

13.2.7 Extending the Length of COBRA Coverage

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

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

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

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

A member must provide the COBRA Administrator a copy of the Social Security Administration's determination within the 18-month period following the subscriber's termination of employment or reduction of hours, and not later than 60 days after the Social Security Administration's determination was made. If the notice is not provided within this timeframe, then there will be no disability extension of COBRA coverage. The premiums for COBRA coverage may increase after the 18th month of coverage to 150% of the 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. Such second qualifying events may include the death of a subscriber, divorce or legal separation from the subscriber, or a child's ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the member to lose coverage under the Plan if the first qualifying event had not occurred. (This extension is not available under the Plan when a subscriber becomes entitled to Medicare after his or her termination of employment or reduction of hours.).

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

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

13.2.8 Newborn or Adopted Child

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

13.2.9 Special Enrollment and Open Enrollment

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

13.2.10 When Continuation Coverage Ends

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

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

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

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

13.3 UNIFORMED SERVICES EMPLOYMENT & REEMPLOYMENT RIGHTS ACT (USERRA)

Coverage will terminate if a subscriber is called to active duty by any of the armed forces of the United States of America. However, if a subscriber requests to continue coverage under USERRA, coverage can be continued for up to 24 months or the period of uniformed service leave, whichever is shortest, if the subscriber pays any required contributions toward the cost of the coverage during the leave. If the leave is 30 days or less, the contribution rate will be the

same as for active members. If the leave is longer than 30 days, the required contribution will not exceed 102% of the cost of coverage.

If a subscriber does not elect continuation coverage under USERRA or if continuation coverage is terminated or exhausted, coverage will be reinstated on the first day he or she returns to active employment with the Group if released under honorable conditions, but only if he or she returns to active employment:

a. On the first full business day following completion of military service for a leave of 30 days or less
b. Within 14 days of completing military service for a leave of 31 to 180 days
c. Within 90 days of completing military service for a leave of more than 180 days

Regardless of the length of the leave, a reasonable amount of travel time or recovery time for a medical condition determined by the Veteran's Administration (VA) to be service connected will be allowed.

When coverage under the Plan is reinstated, all plan provisions and limitations will apply to the extent that they would have applied if the subscriber had not taken military leave and coverage had been continuous under the Plan. There will be no additional eligibility waiting period. (This waiver of limitations does not provide coverage for any medical condition caused or aggravated by military service, as determined by the VA. Complete information regarding rights under USERRA is available from the Group).

13.4 FAMILY AND MEDICAL LEAVE

If the Group grants a leave of absence under state or federal family and medical leave laws, the following rules will apply:

a. Affected members will remain eligible for coverage during a family and medical leave.
b. If members elect not to remain enrolled during a family and medical leave, they will be eligible to re-enroll in the Plan on the date the subscriber returns from leave. To re-enroll, a complete and signed application must be submitted within 60 days of the return to work. All of the terms and conditions of the Plan will resume at the time of re-enrollment as if there had been no lapse in coverage. Any exclusion period served prior to the leave will be credited and any group eligibility waiting period under the Plan will not have to be re-served. However, no exclusion period credits will be received for the period of the leave.
c. A subscriber's rights under family and medical leave will be governed by applicable state or federal statute and regulations.

13.5 LEAVE OF ABSENCE

A leave of absence is a period off work granted by the Group at a subscriber's request during which he or she is still considered to be employed and is carried on the employment records of the Group. A leave can be granted for any reason acceptable to the Group.

If granted a leave of absence, a subscriber may continue coverage for up to 3 months. Premiums must be paid through the Group in order to maintain coverage during a leave of absence.

13.6 STRIKE OR LOCKOUT

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

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

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

SECTION 14. ERISA DUTIES

Subscribers are entitled to certain rights and protections if the Plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA). Members should check with the Group to determine if this section is applicable.

14.1 PLAN ADMINISTRATOR AS DEFINED UNDER ERISA

Moda Health is not the plan administrator or the named fiduciary of the Plan, as defined under ERISA. Contact the Group for more information.

14.2 INFORMATION ABOUT THE PLAN AND BENEFITS

Subscribers may examine, without charge, at the Group's office and at other specified locations such as worksites, all documents governing the Plan, including insurance contracts, collective bargaining agreements (if applicable), updated summary plan description, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (if any). This information can be obtained by written request. The Group may make a reasonable charge for the copies.

Subscribers are entitled to receive a summary of the Plan's annual financial report, if any is required by ERISA. The Group is required by law to furnish each subscriber with a copy of this summary annual report.

14.3 CONTINUATION OF GROUP HEALTH PLAN COVERAGE

Subscribers are entitled to continue healthcare coverage for themselves or their dependents if coverage under the Plan is lost as a result of a qualifying event. Members may have to pay for such coverage. Members should review this handbook and the documents governing the Plan regarding the rules governing continuation coverage rights.

Members are entitled to reduction or elimination of exclusion periods if they have creditable coverage from another plan. Without evidence of creditable coverage, members may be subject to exclusion periods under the Plan.

14.4 PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for members, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of members. No one, including the employer or any other person, may fire or discriminate against a subscriber in any way to prevent him or her from obtaining a benefit or exercising rights under ERISA.

14.5 ENFORCEMENT OF RIGHTS

If a claim for benefits is denied or no action is taken, in whole or in part, members have a right to receive an explanation, to obtain without charge copies of documents relating to the decision, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps members can take to enforce these rights. For instance, if a copy of plan documents or the latest annual report from the Group is requested and not received within 30 days, a member may file suit in federal court. In such a case, the court may require the Group to provide the materials and pay the member up to $110 a day until he or she receives the materials, unless the materials were not sent because of reasons beyond the control of the Group. If a claim for benefits is denied or no action is taken, in whole or in part, a member may file suit in state or federal court after exhausting the appeal process required by the Plan (see section 10.2). In addition, a member who disagrees with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order may file suit in federal court.

If plan fiduciaries misuse the Plan's money, or if a member is discriminated against for asserting his or her rights, the member may seek assistance from the U.S. Department of Labor or may file suit in federal court. The court will decide who should pay court costs and legal fees. If the member is successful, the court may order the person who has been sued to pay these costs and fees. If the member loses, the court may order him or her to pay these costs and fees, (e.g., if it finds the claim is frivolous).

14.6 ASSISTANCE WITH QUESTIONS

For questions about this section or a member's rights under ERISA, or for assistance obtaining documents from the Group, members should contact the Employee Benefits Security Administration, U.S. Department of Labor, 300 Fifth Avenue, Suite 1110, Seattle, Washington, 98104, telephone 206-757-6781, or the Office of Participant Assistance, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington D.C. 20210, telephone 866-444-3272. Members may also obtain publications about their rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

SECTION 15. PATIENT PROTECTION ACT

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

15.1 What are a member's rights and responsibilities?

Members have the right to:

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

Members have the responsibility to:

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

15.2 What if a member has a medical emergency?

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

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

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

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

A member can file an appeal by contacting Customer Service or by writing a letter to Moda Health (P.O. Box 40384, Portland, Oregon 97240). Complete information can be found in section 10.2.

A member may also contact the Oregon Insurance Division:

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

15.5 What are the prior authorization and utilization review criteria?

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

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

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

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

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

Moda Health protects members' information in several ways:

a. Moda Health has a written policy to protect the confidentiality of health information
b. Only employees who need to access member information in order to perform their job functions are allowed to do so
c. Disclosure outside Moda Health is permitted only when necessary to perform functions related to providing coverage and/or when otherwise allowed by law
d. Most documentation is stored securely in electronic files with designated access

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

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

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

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

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

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

15.9 What additional information is available upon request?

The following documents are available by calling Customer Service:

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

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

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

a. The results of all publicly available accreditation surveys
b. A summary of Moda Health's health promotion and disease prevention activities
c. An annual summary of appeals

d. An annual summary of utilization review policies
e. An annual summary of quality assessment activities
f. An annual summary of scope of network and accessibility of services

Contact:

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

moda HEALTH

For help, call us directly at 888-217-2363.
(En Español: 888-786-7461)

P.O. Box 40384
Portland, OR 97204

modahealth.com