2025

Oregon Group Medical Plan

Group Name
Moda Health Connexus Platinum 250 PPO plan
Group# *123456789*
January 1, 2025

Health Plans in Oregon provided by Moda Health Plan, Inc.

ModaORSGbk 1-1-2025

TABLE OF CONTENTS

SECTION 1. WELCOME TO MODA HEALTH

We are pleased your Group has chosen Moda Health as its preferred provider organization (PPO). This handbook will give you important information about the Plan's benefits, limitations and procedures.

If you have questions, call one of the numbers listed in section 2.1 or use the tools and resources on your Member Dashboard at www.modahealth.com. You can use it 24 hours a day, 7 days a week to get your plan information whenever it is convenient.

This handbook may be changed or replaced at any time, by the Group or Moda Health, without your agreement. You can find the most current handbook on your Member Dashboard. All plan provisions are governed by the Group's policy with Moda Health. This handbook may not contain every plan provision.

We may monitor telephone conversations and email communications you have with us. We will only do this when Moda Health determines there is a legitimate business purpose to do so.

This Plan is not a Medicare Supplement plan. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare. You can get this from the Group.

SECTION 2. MEMBER RESOURCES

2.1 CONTACT INFORMATION

Moda Health Website (log in to your **Member Dashboard**)
www.modahealth.com

Some of the things you can do on your Member Dashboard are:

- Find an in-network provider with Find Care
- Get medication cost estimates and benefit tiers using our Prescription Price Check tool and formulary
- See if a service or supply you need must be prior authorized first (Referral and Authorization link under Resources)

Medical Customer Service Department
888-217-2363
En español 888-786-7461

Behavioral Health Customer Service Department
800-799-9391

Disease Management and Health Coaching
800-913-4957

Hearing Services preferred vendor
TruHearing
866-202-2178

Virtual Care preferred vendor
CirrusMD
Modahealth.com/cirrusmd

Pharmacy Customer Service Department
888-361-1610

Appeals Department
601 SW 2nd Ave., Portland, OR 97204
Fax 503-412-4003
OregonExternalReview@modahealth.com

Telecommunications Relay Service for the hearing impaired
711

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

2.2 MEMBER ID CARD

After you enroll, we will send you ID (identification) cards that show your group and ID numbers, and your provider network. Show your card each time you receive services, so your provider will know you are a Moda Health member. If you lose your ID card, you can get a new one through your Member Dashboard or by calling Customer Service.

2.3 NETWORKS

Network Information (Section 5) explains how networks work. These are the networks for your Plan:

Medical network
Connexus

Pharmacy network
Navitus

Travel network
Aetna® PPO

2.4 CARE COORDINATION

2.4.1 Care Coordination

When you have a complex and/or catastrophic medical situation, our Care Coordinators and Case Managers will work directly with you and your professional providers to coordinate your healthcare needs. Care Coordinators and Case Managers are nurses or behavioral health clinicians. They will coordinate access to a wide range of services spanning all levels of care. Coordinating your care helps you get the right services at the right time.

2.4.2 Disease Management & Health Coaching

If you are living with a chronic disease or medical condition, we want to help you improve your health status, quality of life and productivity. Working with a Health Coach can help you follow the medical care plan your professional provider recommends. Health Coaches provide education and support to help you identify your healthcare goals, self-manage your disease and prevent the development or progression of complications. Contact Disease Management and Health Coaching for more information.

2.4.3 Behavioral Health

Moda Behavioral Health provides specialty services for managing mental health and substance use disorder benefits. We can help you access effective care in the right place and contain costs. Behavioral Health Customer Service can help you find in-network providers and understand your mental health and substance use disorder benefits.

2.5 OTHER RESOURCES

You can find other general information about the Plan in Section 13.

See Section 14 for information about additional services, programs and tools to support your physical, mental and emotional health. These resources are not part of the Plan, and they are not insurance.

SECTION 3. SCHEDULE OF BENEFITS

Look through this section for a quick summary of the Plan's benefits.

You must also read the Benefit Description (Section 7) for more details about any limitations or requirements. Link directly there from the Details column of the table below.

You will find details of the actual benefits in the sections after this summary. You will need to know the conditions, limitations and exclusions of the Plan that are explained there. Prior authorization may be required for some services (see Section 6). Important terms are explained in Section 12.

Cost sharing is the amount you pay. See Section 4 for more information, including an explanation of deductible and out-of-pocket maximum. If you do not use an in-network provider, you may have to pay any amount that is over the maximum plan allowance.

When a benefit has an "annual" or "per year" limit, it will accrue on a calendar year basis unless otherwise specified.

	In-Network Benefits	Out-of-Network Benefits
Annual deductible per member	**$250**	**$3,000**
Maximum annual deductible per family	**$500**	**$6,000**
Annual out-of-pocket maximum per member	**$4,000**	**$10,000**
Maximum annual out-of-pocket maximum per family	**$8,000**	**$20,000**

Services	Amount You Pay		Section in Handbook & Details
	In-network	Out-of-network	
Urgent & Emergency Care			
Ambulance Transportation	10% after deductible In-network deductibles and out-of-pocket maximums apply		Section 7.2.1
Emergency Room Facility (includes ancillary services)	$250 per visit after deductible In-network deductibles and out-of-pocket maximums apply		Section 7.2.2 No copay if admitted to hospital from emergency room
ER professional / ancillary services billed separately	10% after deductible In-network deductibles and out-of-pocket maximums apply		No deductible for diagnostic x-ray and lab
Urgent Care Office Visit	$30 per visit	50% after deductible	Section 7.2.3
Preventive Services			
Services as required under the Affordable Care Act, including:	No cost sharing	Not covered except as stated	Section 7.3

Services	Amount You Pay		Section in Handbook & Details
	In-network	Out-of-network	
Colonoscopy	0%	Not covered	Section 7.3.1 One per 10 years, age 45+
Contraception	0%	Not covered	Section 7.3.2
Immunizations	0%	Not covered	Section 7.3.3
Mammogram	0%	50% after deductible	Section 7.3.8 One per year, age 40+
Pediatric Screenings	0%	Not covered	Section 7.3.4 Age/frequency limits apply
Preventive Health Exams	$0 per visit	Not covered	Section 7.3.5 6 visits in first year of life 7 exams from age 1 - 4 One per year, age 5+
Tobacco Cessation Treatment			Section 7.3.7
Consultation	0%	Not covered	
Supplies		50% after deductible	
Women's Exam & Pap Test	$0 per visit	50% after deductible	Section 7.3.8 One per year
Other Preventive Services including:			
Screening X-ray & Lab	10%	50% after deductible	Section 7.4.10
Prostate Rectal Exam	$15 per visit	50% after deductible	Section 7.3.6 Once every 2 years, age 50+
Prostate Specific Antigen (PSA) Test	10%		
General Treatment Services			
Acupuncture	$15 per visit	50% after deductible	Section 7.4.1 12 visits per year
Anticancer Medication	10% after deductible	50% after deductible	Section 7.4.2
Applied Behavior Analysis	10% after deductible	50% after deductible	Section 7.4.3
Behavioral Health Services		50% after deductible	Section 7.4.4 $5 for first 3 office visits, including PCP office visits
Detoxification (Detox)	10% after deductible		
Office Visits	$15 per visit		
Intensive Outpatient			
Other Outpatient Services	10% after deductible		
Coordinated Specialty Programs	0%		
Inpatient	10% after deductible		
Partial Hospitalization			
Residential Treatment Program			
Biofeedback	$30 per visit	50% after deductible	Section 7.4.5 10 visit lifetime maximum

Services	Amount You Pay		Section in Handbook & Details
	In-network	Out-of-network	
Dental Injury	10% after deductible	50% after deductible	Section 7.4.8
Diabetes Services	10% after deductible	50% after deductible	Section 7.4.9 Supplies covered under Pharmacy benefits
Diagnostic Procedures, including x-ray and lab		50% after deductible	Section 7.4.10
Outpatient	10%		
Inpatient	10% after deductible		
Advanced Imaging	10% after deductible		
Disease Management for Pain	0%	50% after deductible	Section 7.4.11
Durable Medical Equipment (DME) Supplies & Appliances	10% after deductible	50% after deductible	Section 7.4.12 Limits apply to some DME, supplies, appliances
Wigs	67% after deductible	67% after deductible	One per year
Hearing Aids & Related Services		50% after deductible	Section 7.4.14 Frequency limits apply
Exam	$45		
Other services	10%		
Home Healthcare	10% after deductible	50% after deductible	Section 7.4.15 140 out-of-network visits per year
Hospice Care		50% after deductible	Section 7.4.16 Respite care: 5 days in a row, to 30 day lifetime maximum
Home Care	10% after deductible		
Inpatient Care	10% after deductible		
Respite Care	10% after deductible		
Hospital Inpatient Care	10% after deductible	50% after deductible	Section 7.4.17
Hospital Physician Visits	10% after deductible	50% after deductible	Section 7.4.18
Infusion Therapy (Home or Outpatient)	10% after deductible	50% after deductible	Section 7.4.20 Some medications may be limited to certain providers or settings. Certain medications covered under specialty pharmacy benefit.
Kidney Dialysis	10% after deductible	50% after deductible	Section 7.4.21

Services	Amount You Pay		Section in Handbook & Details
	In-network	Out-of-network	
Office and Home Visits			Section 7.4.26 See also Virtual Care Visits
First 3 PCP visits	$5 per visit	50% after deductible	1st 3 visits combined with behavioral health visits, and including virtual care visits Naturopathic physicians are considered specialists unless credentialed as a PCP
Additional PCP visits	$15 per visit		
Specialist visits	$30 per visit		
Rehabilitation & Habilitation (Physical, occupational and speech therapy)		50% after deductible	Section 7.4.29 Rehabilitation and habilitation up to 30 outpatient sessions and 30 inpatient days per year. Rehabilitation up to 60 sessions for neurologic conditions or 60 inpatient days after acute head/spinal cord injury
Outpatient	$15 per visit		
Inpatient	10% after deductible		
Skilled Nursing Facility Care	10% after deductible	50% after deductible	Section 7.4.30 60 days per year
Spinal Manipulation	$15 per visit	50% after deductible	Section 7.4.31 20 visits per year
Surgery & Invasive Diagnostic Procedures		50% after deductible	Section 7.4.32
Outpatient	10% after deductible		
Inpatient	10% after deductible		
Therapeutic Injections	10% after deductible	50% after deductible	Section 7.4.33
Therapeutic Radiology	10% after deductible	50% after deductible	Section 7.4.34
Transplants			Section 7.4.35 $7,500 maximum travel and housing per transplant
Center of Excellence facilities	10% after deductible	N/A	
Other facilities	Not covered		
Virtual Care Visits			Section 7.4.36
Through CirrusMD	$0 per visit	N/A	Log on via modahealth.com/cirrusmd
Other providers		50% after deductible	Combined with in-person visits (PCP and behavioral health visits)
First 3 visits	$5 per visit		
Additional visits	$10 per visit		

Services	Amount You Pay		Section in Handbook & Details
	In-network	Out-of-network	
Maternity Services			
Breastfeeding			Section 7.5.2
Support and Counseling	0%	50% after deductible	
Supplies		0%	
Maternity	10% after deductible	50% after deductible	Section 7.5
Newborn Home Visiting Program	0%	50% after deductible	Section 7.5.5 Visit limits apply
Pharmacy			
Prescription Medication	If you use an out-of-network pharmacy, you must pay any amounts charged above the MPA		Section 7.6
Retail Pharmacy			Up to 30-day supply per prescription $35 max cost share for insulin
Value Tier	$2		
Select Tier	$10		
Preferred Tier	$30		
Nonpreferred Tier	50%		
Mail Order Pharmacy			Up to 90-day supply per prescription $105 max cost share for insulin
Value Tier	$6	Must use Moda-designated mail order pharmacy	
Select Tier	$30		
Preferred Tier	$90		
Nonpreferred Tier	50%		
Specialty Pharmacy			Up to 30-day supply per prescription for most medications
Preferred Specialty	25%	Must use Moda-designated specialty pharmacy	
Nonpreferred Specialty	50%		
Anticancer Medication	10% Must use Moda-designated pharmacy for mail order and specialty		Section 7.4.2
Vision			
Pediatric Vision Care			Section 7.7.1 Once per year under age 19
Exam	$0 per visit	50% after deductible	
Lenses & frames or contacts	0%		
Adult Vision Services	0%		Section 7.7.2 Age 19+ $200 annual maximum

SECTION 4. PAYMENT & COST SHARING

4.1 DEDUCTIBLES

Every year, you will have to pay some expenses before the Plan starts paying. This is called meeting or satisfying your deductible. The deductible is lower when you use in-network providers. You must pay all covered expenses until you have spent the deductible amount, unless the Plan specifically says there is no deductible. Then the Plan begins sharing costs with you. The deductible amounts, and the amount you pay after the deductible is met, are shown in Section 3. In-network and out-of-network services have separate deductibles. If more than one member of your family is covered, you only have to pay your per member deductible until the total family deductible is reached.

Disallowed charges, copayments and some manufacturer discounts and/or copay assistance programs do not count toward your annual deductible.

If the Group has changed coverage to a policy with Moda Health, we will credit any deductible you met under your old plan during the year to your new Moda Health Plan.

Your deductible is added up on a calendar year basis. If the Plan renews on a date other than January 1st, you may have to meet some additional deductible after renewal through December 31st.

4.2 MAXIMUM OUT-OF-POCKET

The Plan helps protect you from very high medical costs. The out-of-pocket maximum is an upper limit on how much you have to pay for covered charges each year. Once you have paid the maximum amount, the Plan will pay 100% of covered services for the rest of the year. If more than one member of your family is covered, the per member maximum applies only until the total family out-of-pocket maximum is reached, even if no single family member has reached the per member maximum. In-network and out-of-network out-of-pocket maximums add up separately and are not combined.

Out-of-pocket costs are added up on a calendar year basis. If the Plan renews on a date other than January 1st, you may have to pay more out-of-pocket costs after renewal through December 31st.

Payments made by manufacturer discounts and/or copay assistance programs may not count toward your out-of-pocket maximum.

You will always have to pay disallowed charges, even after your out-of-pocket maximum is met. Disallowed charges may include amounts over the MPA and extra expenses you pay when you use a brand medication when a generic is available.

4.3 PAYMENT

Moda Health pays covered expenses based on the maximum plan allowance (MPA). The MPA is defined in Section 12. You may have to pay some of the charges (cost sharing). What you have to pay depends on the Plan provisions.

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

4.4 EXTRA-CONTRACTUAL SERVICES

Moda Health works with you and your professional providers to consider effective alternatives to hospitalization and other care to make more efficient use of the Plan's benefits. If we believe a service or supply is medically necessary, cost effective and beneficial for quality of care, we may cover the service or supply even though the Plan does not allow it. This is called an extra-contractual (outside the Plan contract) service.

After case evaluation and analysis by Moda Health, extra-contractual services will be covered when Moda Health, and you and your professional provider, agree. Any of us can end these services by giving notice in writing.

The fact that the Plan has paid benefits for extra-contractual services for a member does not obligate it to pay such benefits for any other member, nor does it obligate the Plan to pay benefits for continued or additional extra-contractual services for the same member. Extra-contractual benefits paid under this provision will be included in calculating any benefits, limitations or cost sharing under the Plan.

SECTION 5. NETWORK INFORMATION

When you use an in-network provider, you will receive quality healthcare and will have a higher level of benefits. Use Find Care on your Member Dashboard to choose an in-network provider. You may contact Customer Service if you need help. Your member ID card will list your network.

When you are at an in-network facility, your care may be provided by physicians, anesthesiologists, radiologists or other professionals who are not in-network. When you receive services from these out-of-network providers, you may have to pay any amounts charged above the MPA(see section 5.1.4). This is called balance billing. Remember to ask providers to send any lab work or x-rays to an in-network facility.

When you choose an out-of-network provider, you will get out-of-network benefits for those services.

5.1 GENERAL NETWORK INFORMATION

5.1.1 Network and Service Area

Your network provides services in your service area. If the subscriber lives outside the primary service area, you may have other networks you can use. Subscribers who move outside of their network service area must contact Customer Service to find out if another network is available, so you can continue to access in-network providers.

Ask your providers (both professional providers and facilities) if they participate with the specific network listed below. Do not ask if the provider accepts Moda. There are many Moda Health networks. A provider may accept Moda insurance, but not be participating with the network for your Plan. Contact Customer Service if you need help finding an in-network provider.

Networks
Medical network is Connexus,
with providers in Oregon, southwest Washington and Idaho counties that border Oregon

Pharmacy network is Navitus

5.1.2 Out-of-Area Network for Children

Enrolled children living in the United States but outside the service area may be assigned to the out-of-area network.

When your enrolled child moves outside the service area, you must contact Customer Service and the subscriber's employer to update the address with Moda Health. Out-of-area coverage starts the first day of the month after the date supporting documentation is received and the address is updated in our system.

If the child is living outside the service area for the purpose of receiving treatment, services will be out-of-network.

Out-of-Area Network
Aetna® PPO

Find an out-of-area network provider by using Find Care on your Member Dashboard. You may contact Customer Service if you need help.

When you are traveling in the primary network service area, you must use the primary network, even though you are assigned to the out-of-area network. Tell us when you move back into the service area.

5.1.3 Travel Network

When you are traveling outside of your service area, you have in-network coverage when you use a provider from the travel network.

You may only use a travel network provider if:

a. You are outside your primary service area
b. You need urgent or emergency care
c. You are not traveling for the purpose of receiving treatment or benefits (medical tourism)

The travel network is not available if your assigned network provides nationwide access.

Travel Network
Aetna® PPO

Find a travel network provider by using Find Care on your Member Dashboard. You may contact Customer Service if you need help.

5.1.4 Out-of-Network Care

When you choose healthcare providers that are not in-network, your benefits are lower, at the out-of-network level shown in Section 3. You may have to pay all of the charges when you get the treatment, and then file a claim to get your out-of-network benefits. If the provider's charges are more than the maximum plan allowance, you may be balance billed and have to pay those excess charges.

When you are getting care at an in-network facility, ask to have related services (such as diagnostic testing, equipment and devices, telemedicine, anesthesia, surgical assistants) performed by in-network providers. When you are at an in-network facility and are not able to choose the provider, you will have the in-network cost sharing for services by out-of-network providers. The provider cannot balance bill you unless permitted by law.

Special Circumstances
We will pay an out-of-network provider at the in-network benefit level when you need emergency care (section 7.2) or for continuity of care (section 9.3). We may also allow the in-network benefit level in these situations:

a. Transition of care: You are a new member and in the middle of treatment with a provider who is out-of-network with us when your coverage under the Plan starts. We may pay in-network benefits for a limited time, while you complete treatment with your provider or your care is safely transferred to an in-network provider
b. Network adequacy: You need care and there is not an in-network provider within a reasonable distance who can provide timely, cost-effective services to you

In-network benefits are not automatic (except for emergency services). You or your provider must ask us to prior authorize in-network benefits (see section 6.1.3). We will review your request, and if the criteria are met, we will pay at the in-network benefit level. You will have to pay any charges that are over the maximum plan allowance.

5.1.5 Care After Normal Office Hours

In-network professional providers have an on-call system so you can reach them 24 hours a day. If you need to talk to your professional provider after normal office hours, call their regular office number.

5.1.6 Primary Care Provider (PCP)

The Plan is designed to support your healthcare needs through partnership between you and an in-network primary care provider (PCP) who can coordinate your care. You must choose an in-network PCP and tell us who it is when you enroll. If you do not, we will assign one to you.

You can change your PCP at any time through your Member Dashboard or by calling Customer Service. Use Find Care on your Member Dashboard to see a list of in-network PCPs, or ask Customer Service for help. Each member of your family may choose a different PCP. A PCP may be a family or general practitioner, a pediatrician or a women's healthcare provider.

A women's healthcare provider is an in-network obstetrician or gynecologist, physician associate or advanced registered nurse practitioner specializing in women's health, or certified nurse midwife, practicing within their lawful scope of practice. To select a women's healthcare provider as your PCP, they must meet certain standards and must have requested and received designation from us as a PCP.

5.2 USING FIND CARE

Find Care is our online directory of in-network providers. To search for in-network providers, log in to your Member Dashboard at modahealth.com and click on Find Care. Search for a specific provider by name, specialty or type of service, or look in a nearby area using ZIP code or city.

5.2.1 Primary Care Providers

To use this plan, you must choose a PCP. To find a PCP:

a. Choose the "PCP on Connexus" option under the Type drop down menu
b. Enter ZIP code and Search

The search will bring up a list of PCPs.

5.2.2 DME Providers

Find a preferredDME provider for savings on your DME:

a. Choose the "Durable Medical Equipment" option under the Specialty drop down menu
b. Enter ZIP code and Search

The search will bring up a list of preferred DME providers. Preferred DME providers have a ribbon icon next to their network name.

SECTION 6. PRIOR AUTHORIZATION

We use prior authorization to make sure your treatments are safe, that services and medications are used correctly, and that cost-effective treatment options are used. When a service requires prior authorization, we evaluate it using evidence based criteria that align with medical literature, best practice clinical guidelines and guidance from the FDA. We will authorize medically necessary services, supplies or medications based on your medical condition. You may be required to use a preferred treatment center or provider for the treatment to be covered. Treatments are covered only when there is medical evidence of need.

When your professional provider suggests a type of service that requires authorization (see section 6.1.1), ask your provider to contact Moda Health for prior authorization before you receive the service. Emergency hospital admissions must be authorized by your provider within 48 hours after you are admitted (or as soon as reasonably possible). We will send a letter to tell the hospital, professional provider and you whether the services are authorized. Prior authorization does not guarantee your services will be covered. When a service is otherwise excluded from benefits, charges will be denied.

6.1 PRIOR AUTHORIZATION REQUIREMENTS

When you use an out-of-network provider, you are responsible for making sure that your provider contacts us for prior authorization. If your services are not authorized in advance, we will not pay any benefits. You will have to pay the full charge. Any amounts that you have to pay because you did not get a prior authorization do not count toward your deductible or out-of-pocket maximum.

In-network providers are responsible for obtaining prior authorization for you. If your in-network providers do not do so, they are expected to write off the full charge of the service.

Prior authorization is not required for an emergency admission.

6.1.1 Services Requiring Prior Authorization

Many of the following types of services may require prior authorization:

a. Inpatient services and residential programs
b. Outpatient services
c. Rehabilitation (physical, occupational, speech therapy)
d. Spinal manipulation
e. Diagnostic services, including imaging services
f. Infusion therapy
g. Disease management for pain
h. Medications

A full list of services and supplies that must be prior authorized is on the Moda Health website. We update the list from time to time. Ask your provider to check and see if a service or supply requires authorization. You may find out about your authorizations by contacting Customer Service. For mental health or substance use disorder services, contact Behavioral Health Customer Service.

6.1.2 Prior Authorization Limitations

Prior authorization may limit the services that will be covered. Some limits that may apply are:

a. An authorization is valid for a set period of time. Authorized services you get outside of that time may not be covered
b. The treatment, services or supplies/medications that will be covered may be limited
c. The number, amount or frequency of a service or supply may be limited
d. You may have to get treatment from a preferred treatment center or other certain provider for the service or supply to be covered. For some treatments, travel expenses may be covered

Any limits or requirements that apply to authorized services will be described in the authorization letter that is sent to you and your provider. If you are working with a Care Coordinator or Case Manager (see section 2.4), they can help you understand how to access your authorized treatment.

6.1.3 Out-of-Network Services

If you cannot find an in-network provider or you need to transition your care to an in-network provider (see special circumstances in section 5.1.4), ask for prior authorization. When we cannot find an in-network provider for you, or while you are changing your care to an in-network provider, we may prior authorize your out-of-network care at the in-network benefit level.

When we authorize use of an out-of-network provider, you must make sure that the provider contacts Moda Health for prior authorization of any services that require it.

6.1.4 Second Opinion

We may ask you to see another provider for an independent review to confirm that non-emergency treatment is medically necessary. When we do this, you will not pay anything for the second opinion.

If you choose to get a second opinion, this will be paid under your regular medical benefits. You will have to pay any deductible and other cost sharing that applies.

SECTION 7. BENEFIT DESCRIPTION

The Plan covers services and supplies described in this handbook when they are medically necessary to diagnose and/or treat a medical condition, or are preventive services. We explain the benefits and the conditions, limitations and exclusions in the following sections. An explanation of important terms is in Section 12.

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

Many services must be prior authorized (see section 6.1). Sometimes you will have to use a certain provider for the service. If your services are not authorized in advance or you do not use the authorized provider, we will not pay any benefits. You may have to pay the full charge.

7.1 WHEN BENEFITS ARE AVAILABLE

We only pay claims for covered services you get when your coverage is in effect. Coverage is in effect when:

a. You meet the eligibility provisions of the Plan
b. You have applied for coverage and we have enrolled you on the Plan
c. The Group has paid your premiums on time for the current month

Benefits are only payable after the service or supply has been provided. If a limitation or exclusion applies, benefits will not be paid.

Care you get outside the United States is only covered for an urgent care or emergency medical condition.

7.2 URGENT & EMERGENCY CARE

Emergency services and urgent care are covered. Emergency services are covered at the in-network benefit level. You are covered for treatment of emergency medical conditions (as defined in Section 12) worldwide. If you believe you have a medical emergency, call 911 or seek care from the nearest appropriate provider.

If you get emergency care outside the United States, you will have to pay for those services at that time and send a claim to us as described in section 9.1.1.

7.2.1 Ambulance Transportation

Medically necessary ground or air ambulance transport, or secure transport, to the nearest facility that is able to provide the treatment you need is covered. Ambulance providers are usually out-of-network. Out-of-network ground ambulance providers may balance bill you.

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

7.2.2 Emergency Room Care

Medically necessary emergency room care is covered. The emergency room benefit is for services billed by the facility. This may include supplies, labs, x-rays and other charges. Professional fees such as the emergency room physician or reading an x-ray/lab result that are billed separately are paid under inpatient or outpatient benefits.

All claims for emergency services (as defined in Section 12) will be paid at the in-network benefit level. Even when you use an in-network emergency room, some of the providers working in the emergency room and/or hospital may be out-of-network providers (see section 5.1.4 for more information). At an out-of-network emergency room, you cannot be balance billed unless permitted by law.

If you are admitted to the hospital immediately after emergency services, you will not have to pay any emergency room facility copayments. You will still need to pay any cost sharing for the hospital and other charges.

Prior authorization is not needed for emergency medical screening exams or treatment to stabilize an emergency medical condition. Let your PCP know as soon as possible about any emergency care that you receive.

If you must be admitted to an out-of-network facility, your treating or attending physician will monitor your condition. When they determine you can be safely transferred to an in-network facility, the Plan will stop paying in-network benefits for care at the out-of-network facility.

The in-network benefit level is not available for out-of-network care that is not emergency medical care. These are some examples of services that are not for treatment of emergency medical conditions:

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

You should not go to an emergency room for these types of services.

7.2.3 Urgent Care

When you have a minor but urgent medical condition that is not a significant threat to your life or health, short-term medical care at an urgent care facility is covered. You must be actually examined by a professional provider.

An urgent care facility is an office or clinic distinct from a hospital emergency room. Its purpose is to diagnose and treat illness or injury for patients without an appointment who are seeking immediate medical attention.

Note: Most walk-in or same-day clinics and immediate care facilities do not bill as urgent care facilities. If you go one of these facilities, the visit will be covered under the office visit benefit (section 7.4.26). Services will not be paid under your urgent care benefits unless the facility you go to bills as an urgent care facility.

7.3 PREVENTIVE SERVICES

Under the Affordable Care Act (ACA), certain services are covered at no cost to you when you get the care from an in-network provider (see Section 3 for benefit level when services are provided out-of-network). Coverage limitations are based on reasonable medical management techniques where permitted by the ACA. This means that you may have member cost sharing for some alternatives in the services listed below:

a. Evidence-based services rated A or B by the United States Preventive Services Taskforce (www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations/) and including women's services as of January 1, 2023
b. Immunizations recommended by the Advisory Committee on Immunization Practices of the Center for Disease Control and Prevention (ACIP)(www.cdc.gov/vaccines/hcp/acip-recs/)
c. Preventive care and screenings recommended by the Health Resources and Services Administration (HRSA) for infants, children and adolescents (downloads.aap.org/AAP/PDF/periodicity_schedule.pdf), and women (www.hrsa.gov/womensguidelines/) and including women's services as of January 1, 2023

If one of these organizations makes a new or updated recommendation, it may be up to one year before the related services are covered at no cost sharing.

The Moda Health website has a list of preventive services covered at no cost sharing as required by the ACA. You may also call Customer Service to find out if a preventive service is on this list. Other preventive services have member cost sharing when not prohibited by federal law. Some commonly used preventive services covered by the Plan are:

7.3.1 Colorectal Cancer Screening

One of the following services, including related charges such as consultations and pre-surgical exams, if you are age 45 or over:

a. Fecal occult blood test (FOBT) or fecal immunochemical test (FIT) every year
b. Fecal DNA test every 3 years
c. CT colonography, flexible sigmoidoscopy or double contrast barium enema every 5 years
d. Flexible sigmoidoscopy every 10 years plus FIT every year
e. Colonoscopy, including polyp removal, every 10 years

With the exception of colonoscopy, screening tests involve 2 steps. If you have a positive result on a USPSTF-recommended screening covered under the preventive benefit, one follow-up colonoscopy to confirm the results of the original screening will also be covered under the preventive benefit as part of the screening procedure.

Anesthesia for colorectal cancer screening is covered under the preventive benefit. Anesthesia for your colonoscopy under the preventive benefit does not need prior authorization. All other anesthesia for colorectal cancer screening must be prior authorized.

These screening timelines apply to you if you are not a high risk for colorectal cancer. You may be screened earlier or more often if it is medically necessary. You are high risk if you have a family medical history of known genetic disorders that predispose you to a high lifetime risk of colorectal cancer (such as Lynch syndrome), you have had colorectal cancer or an adenomatous polyp before, or you have had inflammatory bowel disease.Screening exams and laboratory tests,

including a follow-up colonoscopy to check progress of the original findings, are paid at the medical benefit level if you do not meet the criteria for the USPSTF A or B rated recommendation.

7.3.2 Contraception

All FDA approved contraceptive methods, including sterilization, and counseling are covered. When you use an in-network provider and the most cost effective option (e.g., generic instead of brand name), you will not have to pay for contraception. If there is not an in-network provider within a reasonable distance who can provide timely, cost-effective contraceptive services to you, ask Customer Service for help. We may prior authorize services at no cost sharing with an out-of-network provider. If your provider determines the cost-effective contraceptive is medically inadvisable for you, we will cover an alternative that they prescribe. Over the counter contraceptives are covered under the Pharmacy benefit (section 7.6). Contraceptives do not need to be prior authorized and you do not have to try step therapy. Surgery to reverse a vasectomy or tubal ligation is not covered.

7.3.3 Immunizations

Routine immunizations are limited to those recommended by the ACIP. Immunizations only for travel or to prevent illness that may be caused by your work environment are not covered, except as required under the Affordable Care Act.

7.3.4 Pediatric Screenings

At the frequency and age recommended by HRSA or USPSTF, including:

a. Screening for hearing loss in newborn infants
b. Routine vision screening to detect amblyopia, strabismus and defects in visual sharpness in children age 3 to 5
c. Developmental and behavioral health screenings

7.3.5 Preventive Health Exams

Covered according to the following schedule:

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

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

You will have to pay the standard cost sharing for routine diagnostic x-ray and lab work related to a preventive health exam that is not required by the ACA.

7.3.6 Prostate Rectal Exam & Prostate Specific Antigen (PSA) Test

Cost sharing applies to prostate rectal exams and PSA tests. If you are age 50 or over, one rectal exam and one PSA test is covered every 2 years. If you are at high risk for prostate cancer, a prostate rectal exam and PSA test are covered earlier or more often if your professional provider recommends it.

7.3.7 Tobacco Cessation

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

A tobacco cessation program can provide an overall treatment program that follows the United States Public Health Service guidelines for tobacco use cessation. You may have more success with a coordinated program.

7.3.8 Women's Healthcare

Preventive women's healthcare visits, including one pelvic and breast exam and one Pap test each year. 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 imaging, for screening or diagnosis if you have symptoms or are high risk are also covered when your professional provider decides it is necessary. Pap tests are covered under the office visit or lab test benefit level if they are not within the Plan's age and frequency limits for preventive screening.

7.4 General Treatment Services

All services must be medically necessary. Many outpatient services must be prior authorized. All nonemergency inpatient and residential care must be prior authorized. Some services may need a separate prior authorization. If your doctor does not get the required prior authorization, the charges will not be covered. You may have to pay the full cost. See section 6.1 for more information about prior authorization.

7.4.1 Acupuncture

A limited number of visits are covered each year. Other services you may get at an acupuncture visit, such as office visits or diagnostic services, are not covered under this benefit. They are paid under the Plan's standard benefit for the type of service. If the copayments for acupuncture and related services are different, you will have to pay the highest copayment at any one visit with the same provider. You will also have to pay any coinsurance that applies. Office visits by acupuncturists are specialist office visits.

7.4.2 Anticancer Medication

Prescribed anticancer medications, including oral, intravenous (IV) or injected medications, are covered. Most anticancer medications need to be prior authorized and have specific benefit limitations. You must get specialty anticancer medications from our designated specialty pharmacy (see section 7.6.4). For some anticancer medications, you may have to enroll in programs to help make sure the medication is used correctly and/or lower the cost of the medication. You can find more information on your Member Dashboard or by contacting Customer Service.

7.4.3 Applied Behavior Analysis (ABA)

Applied behavior analysis (ABA) is a type of treatment for individuals with autism spectrum disorder (formerly called pervasive developmental disorder. ABA is a variety of psychosocial interventions that use behavioral principles to shape behavior. It includes direct observation, measurement and functional analysis of the relationship between environment and behavior.

Goals include improving daily living skills, decreasing harmful behavior, improving social functioning and play skills, improving communication skills and developing skills that result in greater independence. ABA for autism spectrum disorder is covered. Services must be prior authorized.

Examples of what we do not cover:

a. Services provided by your family or household members
b. Custodial or respite care, equine assisted therapy, creative arts therapy, wilderness or adventure camps, music therapy, neurofeedback, chelation or hyperbaric chamber
c. Services provided under an individual education plan (IEP) to comply with the Individuals with Disabilities Education Act
d. Services provided by the Department of Human Services or Oregon Health Authority

7.4.4 Behavioral Health

Behavioral health conditions are mental health and substance use disorders covered by the diagnostic categories listed in the most current edition of the International Classification of Disease or Diagnostic and Statistical Manual of Mental Disorders.

Intensive outpatient mental health treatment and TMS must be prior authorized. Coordinated specialty programs must be prior authorized or authorized as soon as reasonably possible after you start them. See section 7.4.10 for coverage of diagnostic services.

Intensive outpatient services are more intensive than routine outpatient and less intensive than a partial hospital program.

a. Mental health intensive outpatient is 3 or more hours per week of direct treatment
b. Substance use disorder intensive outpatient is 9-19 hours per week for adults or 6-19 hours per week for adolescents

A partial hospital program is an appropriately licensed behavioral health facility providing no less than 4 hours of direct, structured treatment services per day. Substance use disorder programs provide 20 or more hours of direct treatment per week. Partial hospital programs do not provide overnight 24-hour care.

A residential program is a state-licensed program or facility providing an organized full-day or part-day program of treatment. Residential programs provide overnight 24-hour care and include programs to treat behavioral health conditions. Residential program does not include any program that provides less than 4 hours per day of direct treatment services.

Mental Health

These services by a mental health provider are covered:

a. Behavioral health assessment
b. Office or home visits, including psychotherapy
c. Intensive outpatient program
d. Case management, skills training, wrap-around services and crisis intervention
e. Coordinated specialty program
f. Transcranial magnetic stimulation (TMS) and electroconvulsive therapy
g. Partial hospitalization, inpatient and residential mental health care

Coordinated Specialty Programs
Mental health care as part of a coordinated specialty program is covered. These programs provide multidisciplinary, team-based care to you and your family. Treatment must be authorized. When you do not have time to get prior authorization, your provider should tell us as soon as possible after you have been admitted.

Coordinated specialty programs are:

a. Early Assessment and Support Alliance (EASA) and Assertive Community Treatment (ACT) provided by Community Mental Health Programs
b. Intensive Outpatient Services and Supports (IOSS)
c. Intensive In-Home Behavioral Health Treatment (IBHT)

Programs must operate under a Certificate of Approval from the Oregon Health Authority to qualify.

Substance Use Disorder Services
Substance use disorder is an addictive physical and/or psychological relationship with any drug or alcohol that interferes on a recurring basis with main life areas such as employment, and psychological, physical and social functioning. Substance use disorder does not mean an addiction to or dependency upon foods, tobacco or tobacco products. Services to assess and treat substance use disorder are covered, including:

a. Outpatient treatment programs. These are state-licensed programs that provide an organized outpatient course of treatment, with services by appointment
b. Room and treatment services for substance use detoxification by a state-licensed treatment program

7.4.5 Biofeedback
Biofeedback therapy services are only covered to treat tension or migraine headaches or urinary incontinence. There is a lifetime limit to how many visits we will cover.

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

7.4.7 Clinical Trials
If you are enrolled in or participating in an approved clinical trial, usual care costs are covered. Usual care costs are medically necessary conventional care, items or services that are covered by the Plan if you get them outside of a clinical trial. The cost sharing will be the same as if the care was not part of a clinical trial.

The Plan does not cover items or services:

a. That are not covered by the Plan if you get them outside of the clinical trial. This includes the drug, device or service being tested, even if it is covered in a different use outside of the clinical trial
b. Required only to provide or appropriately monitor the drug, device or service being tested in the clinical trial
c. Provided only for data collection and analysis needs and that are not used for your direct medical care

d. Usually provided by a clinical trial sponsor free of charge to anyone participating in the clinical trial

We must prior authorize your participation in a clinical trial. Approved clinical trials are limited to those that are:

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

7.4.8 Dental Injury

Dental services are not covered, except to treat an accidental injury to your natural teeth. Natural teeth are teeth that grew in your mouth.

To be covered, all of the following must be true:

a. The accidental injury must have been caused by a foreign object or was caused by acute trauma (for example, if your tooth breaks when you are biting or chewing food, that is not an accidental injury)
b. Diagnosis is made within 6 months of the date you were injured
c. Treatment is completed within 12 months of the date of injury
d. Treatment is medically necessary and you get it from a physician or dentist while you are enrolled in the Plan
e. Treatment is limited to that which will restore your teeth to a functional state

Implants and implant related services are not covered.

7.4.9 Diabetes Services

Insulin and diabetic supplies including insulin syringes, needles and lancets, test strips, glucometers and continuous glucose monitors are covered under the pharmacy benefit (section 7.6), when you buy them from a pharmacy with a valid prescription and using a preferred manufacturer (see the preferred drug list on your Member Dashboard). Insulin pumps may be covered under the DME benefit (section 7.4.24) if you do not get them from a pharmacy.

Examples of covered medical services to screen and manage your diabetes include:

a. HbA1c lab test
b. Checking for kidney disease
c. Annual dilated eye exam or retinal imaging, including one by an optometrist or ophthalmologist
d. Diabetes self-management programs
    i. One diabetes assessment and training program after you are diagnosed with diabetes
    ii. Up to 3 hours of assessment and training following a change of your condition, medication or treatment, when you get it from a program or provider with expertise in diabetes
e. Dietary or nutritional therapy

f. Routine foot care (see section 7.4.27)

7.4.10 Diagnostic Procedures

Services must be for treatment of a medical or mental health condition. Diagnostic services include:

a. X-rays and laboratory tests
b. Standard and advanced imaging procedures
c. Psychological and neuropsychological testing
d. Other diagnostic procedures

Your provider must get prior authorization for most advanced imaging services (see section 6.1). This includes radiology (such as MR procedures like MRA and MRI, CT, PET and nuclear medicine) and cardiac imaging. A full list of diagnostic procedures that must be prior authorized is on the Moda Health website, or you may ask Customer Service.

7.4.11 Disease Management for Pain

Structured disease management programs for pain are covered. These programs use a holistic, organized course of treatment to help you manage chronic pain. They incorporate assessment, education, movement therapy and mindfulness training to change your experience of pain and help you improve your functioning. The program must be directed and overseen by a qualified provider. Your provider must get prior authorization.

7.4.12 Durable Medical Equipment (DME), Supplies & Appliances

Equipment and related supplies that help you manage a medical condition are covered. DME is typically for home use and is designed for repeated use.

Some examples of covered DME, supplies and appliances are:

a. CPAP for sleep apnea
b. Glasses or contact lenses, only if you have aphakia or keratoconus
c. Hospital beds and accessories
d. Insulin pumps
e. Intraocular lens within 90 days of cataract surgery
f. Light boxes or light wands
g. Orthotics, orthopedic braces, orthopedic shoes to restore or maintain your ability to do day to day activities or perform your job. If you can get the correction or support you need by modifying a mass-produced shoe, then we will only cover the cost of the modification.
h. Oxygen and oxygen supplies
i. Prosthetics
j. Wheelchair or scooter (including maintenance expenses) limited to one per year under age 19 and one every 3 years age 19 and over
k. Wig once per year if you have hair loss because of chemotherapy or radiation therapy

Diabetic supplies, other than insulin pumps and related supplies, are only covered when you get them from a pharmacy. You must have a prescription and use a preferred manufacturer (see section 7.6 for coverage under Pharmacy benefit).

The Plan covers the rental charge for DME. For most DME, the rental charge is covered up to the purchase price. You can work with your providers to order your prescribed DME.

We encourage you to use a preferred DME provider. You may save money when you do. You can find a preferred provider using Find Care on your Member Dashboard (see section 5.2.2). Change your recurring prescription or automated billing to a preferred DME provider by contacting your current provider and the preferred DME provider and asking for the change.

All supplies, appliances and DME must be medically necessary. Your provider may have to prior authorize some DME (see Section 6). Replacement or repair is only covered if the appliance, prosthetic, equipment or DME was not abused, was not used beyond its specifications and not used in a way that voids its warranty. If we ask you to, you must authorize anyone suppling your DME to give us information about the equipment order and any other records we need to approve a claim payment.

Exclusions
In addition to the exclusions listed in Section 8, we will not cover the following appliances and equipment, even if they relate to a covered condition:

a. Those used primarily for comfort, convenience or cosmetic purposes
b. Those used for education or environmental control (examples under Personal Items in Section 8)
c. Therapeutic devices, except for transcutaneous nerve stimulators (TENS unit)
d. Dental appliances and braces
e. Incontinence supplies
f. Supporting devices such as corsets or compression/therapeutic stockings, except when such devices are medically necessary
g. Testicular prostheses

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

7.4.13 Gender Affirming Treatment

Expenses for gender affirming treatment are covered when you meet the following conditions:

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

Covered services may include:

a. Mental health
b. Hormone therapy (including puberty suppression therapy for adolescents)
c. Surgical procedures (see section 7.4.32) such as:
    i. Breast/chest surgery
    ii. Gonadectomy (hysterectomy/oophorectomy or orchiectomy)
    iii. Reconstruction of the genitalia
    iv. Gender affirming facial surgery

If you cannot find an in-network provider for your gender-affirming care, contact Moda Health for help before going to an out-of-network provider. Out-of-network providers may balance bill you.

7.4.14 Hearing Services

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

We cover these items once every 3 years:

a. One hearing aid per hearing impaired ear
b. Repairs, servicing or alteration of the hearing aid equipment
c. Bone conduction sound processors, if necessary for appropriate amplification and prior authorized (the surgery to install the implant is covered at the surgical benefit level)
d. Hearing assistive technology system, if necessary for appropriate amplification and prior authorized

We also cover:

a. Ear molds and replacement ear molds when medically necessary, at least 4 times per year if you are under age 8 and once per year if you are age 8 or older
b. Initial batteries and one box of replacement batteries per year for each hearing aid

The hearing aid must be prescribed, fitted and supplied by an audiologist or hearing aid specialist and referred by a licensed physician. We may cover a new hearing aid sooner if your existing hearing aid cannot be changed to meet your needs and you are under age 26.

To get the highest benefit level for hearing services, call the Hearing Services preferred vendor to choose an in-network audiologist and schedule a hearing exam. The audiologist will help you choose hearing aids from the selection available to our members by the hearing services vendor through an in-network hearing instrument provider. You can also use other in-network and out-of-network providers, but you may pay more.

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

7.4.15 Home Healthcare

If you are homebound, home healthcare services and supplies from a home healthcare agency are covered. Homebound means that you generally cannot leave home because of your condition. If you do leave home, it must be infrequent, for short times, and mainly to get 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 your home.

Home healthcare must be medically necessary and ordered by your treating practitioner or specialist. Visits are intermittent and must be provided by and require the training and skills of one of the following professional providers:

a. Registered or licensed practical nurse (up to 2 visits per day)
b. Physical, occupational, speech or respiratory therapist (1 visit per day)
c. Licensed social worker (1 visit per day)

Out-of-network home health visits have an annual limit. Home health aides are not covered. If you are in hospice, your home healthcare, home care services and supplies are covered under section 7.4.12 and section 7.4.16.

7.4.16 Hospice Care

A hospice is a private or public hospice agency or organization approved by Medicare and accredited by a nationally recognized entity such as the Joint Commission.

Medically necessary or palliative care is covered when you are terminally ill and not getting any more treatment to cure your terminal illness. Services must be part of your hospice treatment plan. The hospice treatment plan is a written plan of care established and periodically reviewed by your treating provider or specialist, who must certify in the plan that you are terminally ill. The plan must describe the services and supplies for medically necessary or palliative care the approved hospice will provide.

Hospice Home Care

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

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

A home health aide is 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 Inpatient Care

Short term hospice inpatient services and supplies are covered.

Respite Care

Respite care is care for a period of time to give full-time caregivers relief from living with and caring for a member in hospice. It is covered if you need continuous assistance. It must be arranged by the attending professional provider and prior authorized. We cover a limited number of days of respite care in the most appropriate setting. We may cover the services and charges of a non-professional provider, but you must get our approval first. Providing care to allow a caregiver to return to work does not qualify as respite care.

Exclusions

In addition to exclusions listed in Section 8, we do not cover:

a. Hospice services provided to other than the terminally ill member, including out of network bereavement counseling for family members
b. Services and supplies that are not included in your hospice treatment plan or not specifically listed as a hospice benefit

7.4.17 Hospital Care

Inpatient care will only be covered when it is medically necessary. Covered expenses for hospital care are:

a. Hospital room
b. Intensive care unit
c. Isolation care to protect you or other patients from spreading illness
d. Facility charges for surgery performed in a hospital outpatient department
e. Other hospital services and supplies when medically necessary for treatment and ordinarily provided by a hospital

f. Take-home prescription drugs are limited to a 3-day supply at the same benefit level as hospitalization

If you have a serious medical condition that makes a dental procedure risky, or if you cannot be safely and effectively treated in a dental office because you are physically or developmentally disabled, general anesthesia services and related facility charges are covered when you get the dental procedure in a hospital or outpatient clinic. Services must be prior authorized.

A hospital is a facility, including a hospital owned or operated by the state of Oregon, that is licensed to provide surgical, medical and psychiatric care. Services must be supervised by licensed physicians. There is 24-hour-a-day nursing service by licensed registered nurses. Care in facilities operated by the federal government that are not considered hospitals is covered when benefit payment is required by law.

7.4.18 Hospital Visits

This is when you are actually examined by a professional provider in a hospital. Covered expenses include consultations with written reports and second opinion consultations.

7.4.19 Inborn Errors of Metabolism

Inborn errors of metabolism are related to a gene that is missing or abnormal at birth that affects how your body metabolizes proteins, carbohydrates and fats. We cover treatment for inborn errors of metabolism that have medically standard ways to diagnose, treat and monitor them. Covered services include nutritional and medical care such as clinical visits, biochemical analysis and medical foods used to diagnose, monitor and treat such disorders.

7.4.20 Infusion Therapy

We cover the following medically necessary infusion therapy services and supplies.

a. solutions, medications, and pharmaceutical additives
b. pharmacy compounding and dispensing services
c. durable medical equipment (DME) for the infusion therapy
d. ancillary medical supplies
e. nursing services
f. collection, analysis, and reporting of the results of laboratory testing services needed to monitor your response to therapy

Your provider must get prior authorization for infusion therapy. You may have to use a preferred medication supplier, home infusion provider or provider office infusion for some medications. When we limit authorization to a certain supplier, provider or setting, medications you get from other suppliers or infusion therapy administered at a hospital outpatient facility or other in-network provider may not be covered. Some infusion medications from a preferred medication supplier are covered under the pharmacy specialty medication benefit (see Section 3 and section 7.6.4). See section 7.6.5 for self-administered infusion therapy. Some services and supplies are not covered if your provider bills them separately. They are considered included in the cost of other billed charges.

7.4.21 Kidney Dialysis

Covered expenses include:

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

7.4.22 Maxillofacial Prosthetic Services

Maxillofacial prosthetic services you need to restore and manage head and facial structures that cannot be replaced with living tissue are covered when you need these services to:

a. Control or eliminate infection or pain
b. Restore facial configuration or functions such as speech, swallowing or chewing

The problem must be because of:

a. Disease
b. Trauma
c. Birth and developmental deformities

Cosmetic procedures to improve on the normal range of conditions are not covered.

7.4.23 Medication Administered by Provider, Treatment/Infusion Center or Home Infusion

A medication that must be given in a professional provider's office, treatment or infusion center or home infusion is usually covered at the same benefit level as supplies and appliances (see Section 3).

Some medications will not be covered unless you use a preferred treatment center. The treatment program may include office visits, testing, a stay at the treatment center and the medication. Sometimes travel expenses may be included. Treatment must be prior authorized (see section 6.1).

Some medications may not be covered unless you get them from a preferred medication supplier. In this case, the medication is covered under the pharmacy specialty medication benefit.

See section 7.4.20 for more information about infusion therapy. Self-administered medications are not covered under this benefit (see section 7.6.5). See section 7.6 for pharmacy benefits.

7.4.24 Nonprescription Enteral Formula for Home Use

The Plan covers nonprescription elemental enteral formula that you use at home. The formula must be medically necessary and ordered by a physician to treat severe intestinal malabsorption. It must be your sole source, or an essential source, of nutrition.

7.4.25 Nutritional Therapy

Dietary or nutritional therapy:

a. Assessing your overall nutritional status
b. Individualized diet and nutritional counseling

Preventive nutritional therapy required under the Affordable Care Act is covered at no cost to you:

a. If you have a body mass index (BMI) 30 kg/m^2 or higher
b. If you are overweight or obese and have cardiovascular disease risk factors
c. For children age 6 years and older who are overweight or obese
d. If you are female and age 40 to 60 with normal or overweight BMI, to maintain weight or limit weight gain

Also see diabetes services (section 7.4.9) and inborn errors of metabolism (section 7.4.19). Nutritional therapy does not include medical foods or nutritional supplements.

7.4.26 Office or Home Visits

A visit means you are actually examined by a professional provider. Covered expenses include consultations with written reports and second opinion surgery consultations. Office visits by naturopathic physicians are specialist office visits unless we have credentialed the naturopathic physician as a primary care provider.

7.4.27 Podiatry Services

Covered to diagnose and treat a specific current problem. Routine podiatry services are not covered unless you have a medical condition (such as diabetes) that requires it.

7.4.28 Pre-admission Testing

Pre-admission testing is covered when ordered by your professional provider.

7.4.29 Rehabilitation & Habilitation

Covered rehabilitation and habilitation services are:

a. Physical therapy
b. Occupational therapy
c. Speech therapy
d. Cardiac rehabilitation
e. Pulmonary rehabilitation

These services must be provided by a licensed physical, occupational or speech therapist, physician, chiropractor or other professional provider licensed to provide such services. Services must be:

a. Medically necessary
b. Part of your professional provider's written treatment plan to improve and restore lost function following illness or injury
c. Inpatient services are in a hospital or other inpatient facility that specializes in such care

Rehabilitative and habilitative services have separate annual limits. These limits do not apply to medically necessary cardiac or pulmonary rehabilitation or services for behavioral health conditions. We may cover more outpatient rehabilitation sessions to treat a neurologic condition (such as stroke, spinal cord or head injury, or pediatric neurodevelopmental problems). If you have an acute head or spinal cord injury, we may cover extra inpatient days. get these additional benefits, you must meet the criteria and your provider must get prior authorization before you have used all of your initial sessions or visits. A session is one visit. Only one session of each type of outpatient physical, occupational or speech therapy is covered in one day.

Rehabilitative services restore or improve an ability you have lost because of a medical condition. Habilitative services are used to form skills that you never developed due to a medical condition.

Outpatient rehabilitative services are short term. Your condition is expected to improve in a reasonable and generally predictable period of time. Therapy you get to prevent a condition or function from getting worse or to maintain a current level of functioning without documented improvement is maintenance therapy and is not covered. Recreational or educational therapy, educational testing or training, non-medical self-help or training, or animal therapy are not covered.

7.4.30 Skilled Nursing Facility Care

A skilled nursing facility is licensed to provide inpatient care under the supervision of a medical staff or a medical director. It provides rehabilitative services and 24-hour-a-day nursing services by registered nurses. A limited number of days are covered. Covered expenses are limited to the daily service rate for a semi-private hospital room.

Exclusions

These skilled nursing facility charges are not covered:

a. If you were admitted before you were enrolled in the Plan
b. If the care is mainly for cognitive decline or dementia, including Alzheimer's disease
c. Routine nursing care
d. Non-medical self-help or training
e. Personal hygiene or custodial care

7.4.31 Spinal Manipulation

Spinal manipulation services must be prior authorized. A limited number of visits are covered each year. Other services you may get at a spinal manipulation visit, such as office visits, lab and diagnostic x-rays, or physical therapy, are not covered under this benefit. They are paid under the Plan's standard benefit for the type of service. If the copayment for spinal manipulation and related services are different, you will have to pay the highest copayment at any one visit with the same provider. You will also have to pay any coinsurance that applies. Office visits by chiropractors are specialist office visits.

7.4.32 Surgery

Surgery (operations and cutting procedures), including treating broken bones, dislocations and burns, is covered. Operating rooms and recovery rooms, surgical supplies and other services ordinarily provided by a hospital or surgical center are covered.

The surgery cost sharing also applies to these 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

Certain surgical procedures are covered only when performed as outpatient surgery. Ask your professional provider if this applies to a surgery you are planning, or ask Customer Service. Outpatient surgery does not require an inpatient admission or a stay of 24 hours or more.

Cosmetic & Reconstructive

Cosmetic surgery is surgery that maintains or changes how you look. It does not improve how your body works. Reconstructive surgery repairs a birth defect or an abnormality caused by injury, infection, tumor or disease. Reconstructive surgery is usually done to improve how your body works, but may also be used to approximate a normal appearance.

Cosmetic surgery is not covered. All reconstructive procedures, including surgical, dental and orthodontic repair of birth defects, must be medically necessary and prior authorized or benefits will not be paid. Reconstructive surgery that is partially cosmetic may be covered if it is medically

necessary. This includes services to treat a covered mental health condition, such as gender dysphoria.

Surgery for breast enhancement, making breasts match, and replacing breast implants to change the shape or size of your breasts is not covered except to treat gender dysphoria (see section 7.4.13) or after a mastectomy.

Reconstructive surgery after a medically necessary mastectomy includes:

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

Treatment for complications related to a reconstructive surgery is covered when medically necessary. Treatment for complications related to a cosmetic surgery is not covered, except to stabilize an emergency medical condition.

7.4.33 Therapeutic Injections

Administrative services for therapeutic injections, such as allergy shots, are covered when you get them in a professional provider's office. When you can get similar results with self-administered medications at home, the administrative services for therapeutic injections by your provider are not covered. Vitamin and mineral injections are not covered unless they are medically necessary to treat a specific medical condition. More information is in sections 7.4.23 and 7.6.5.

7.4.34 Therapeutic Radiology

Covered expenses include:

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

7.4.35 Transplants

A transplant is a procedure or series of procedures by which:

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

We cover medically necessary transplants that follow standard medical practice and are not experimental or investigational. Your provider should get prior authorization as soon as possible after you know you may be a possible transplant candidate. This section’s requirements do not apply to corneal transplants and collecting and/or transfusing blood or blood products (see section 7.4.32).

Benefits for transplants are limited as follows:

a. Transplant procedures must be done at a Center of Excellence. If a Center of Excellence cannot provide the necessary type of transplant, we will prior authorize services at another transplant facility.
b. Donor costs are covered as follows:

i. If you are the recipient or self-donor, donor costs related to a covered transplant are covered. If the donor is also enrolled in the Plan, expenses resulting from complications and unforeseen effects of the donation are covered.
ii. If you are the donor and the recipient is not enrolled in the Plan, we will not pay any benefits toward donor costs.
iii. If the donor is not enrolled in the Plan, expenses that result from complications and unforeseen effects of the donation are not covered.

c. Travel and housing expenses for the recipient and one caregiver are covered up to a maximum per transplant.
d. Professional provider transplant services are paid according to the benefits for professional providers.
e. Immunosuppressive drugs you get during a hospital stay are paid as a medical supply. Outpatient oral and self-injectable prescription medications for transplant related services are paid under the Pharmacy Prescription benefit (section 7.6).
f. We will not pay for chemotherapy with autologous or homogenic/allogenic bone marrow transplant for treatment of any type of cancer not approved for coverage.

A center of excellence is a facility and/or team of professional providers that we have agreements with to provide transplant services. Centers of excellence follow best practices and have exceptional skills and expertise in managing patients with a specific condition.

Donor costs are the covered expenses of removing tissue from the donor's body and preserving or transporting it to the site where the transplant is performed. It includes any other necessary charges directly related to finding and getting the organ.

7.4.36 Virtual Care Visits (Telemedicine)

A virtual care visit is a live, interactive audio and/or video visit with a provider. It includes diagnosis and treatment of chronic or minor medical conditions. Medical information is communicated in real time between you and your provider at different locations using telephone or internet conferencing, or transmission of data from remote monitoring devices.

A virtual care visit is covered if:

a. The covered service can be safely and effectively provided in a virtual care visit
b. The technology used meets all state and federal standards for privacy and security of protected health information

You do not have to pay anything for virtual care visits using the preferred vendor (see Section 3). Additional technologies may be covered, and privacy and security requirements waived, during an Oregon state of emergency.

7.5 MATERNITY CARE

Pregnancy care, childbirth and related conditions are covered when you get the care from a professional provider. Midwives are not considered professional providers unless they are licensed or certified.

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

services, such as amniocentesis and fetal stress test, are not part of global maternity services and are reimbursed separately.

If you have a home birth, the only expenses that are covered are the fees billed by a professional provider. Other home birth charges, such as travel and portable hot tubs, are not covered. Supportive services, such as physical, emotional and information support to you before, during and after birth and during the postpartum period, are not covered expenses except under the newborn home visiting program (section 7.5.5).

7.5.1 Abortion

Abortions are covered at 100 when performed by an in-network provider.

7.5.2 Breastfeeding Support

Support and counseling to help you breastfeed successfully is covered while you are pregnant and/or breastfeeding. We cover the purchase or rental charge for a breast pump and supplies. The maximum plan allowance (MPA) does apply when you buy the pump from a retail store. Charges for extra ice packs or coolers are not covered. Hospital grade pumps are covered when medically necessary.

7.5.3 Circumcision

Circumcision within 3 months of birth is covered without prior authorization. A circumcision after age 3 months must be medically necessary and prior authorized.

7.5.4 Diagnostic Procedures

Diagnostic services, including laboratory tests and ultrasounds, related to maternity care are covered. Some of these procedures may need to be prior authorized. A full list of services that must be prior authorized is on the Moda Health website, or you may ask Customer Service.

7.5.5 Newborn Home Visiting Program (Family Connects)

This program may not be available in all counties. You must use a nurse who is a certified home visiting services provider for services to be covered.

Services include:

a. One comprehensive newborn home visit within 2 to 12 weeks of birth
b. A support visit no more than 2 weeks after birth and before the comprehensive visit if your family has immediate needs after the birth
c. Support telephone calls after the comprehensive home visit
d. One or 2 support visits based on the clinical assessment of the comprehensive home visit
e. A follow-up phone call after the last services provided

Support visits may be a home visit or a virtual care visit. This program ends when your baby is 6 months old.

7.5.6 Office, Home or Hospital Visits

A visit means you are actually examined by a professional provider. In addition to pregnancy care and childbirth visits, nurse home visiting services are covered (see section 7.5.5).

7.5.7 Hospital Benefits

Covered hospital maternity care expenses are:

a. Hospital room

b. Facility charges from a covered facility, including a birthing center
c. Nursery care includes one in-nursery well-newborn infant preventive health exam. You will not have to pay anything when your provider is in-network. Additional visits are covered at the hospital visit benefit level. There is no deductible for routine nursery care. Nursery care is covered under the newborn's own coverage, and is routine while you are in the hospital and receiving maternity benefits.
d. Other hospital services and supplies when medically necessary for treatment and ordinarily provided by a hospital
e. Take-home prescription drugs are limited to a 3-day supply at the same benefit level as for hospitalization

Special Right Upon Childbirth (Newborns' and Mothers' Health Protection Act)
Benefits for any hospital length of stay related to childbirth will not be restricted to less than 48 hours after a normal vaginal delivery or 96 hours after a cesarean section. You may go home earlier if you want to. The attending professional provider for you and your baby will make this decision with you. You do not need a prior authorization to stay in the hospital up to these limits.

7.6 PHARMACY PRESCRIPTION BENEFIT

Prescription medications you get when you are admitted to the hospital are covered by the medical plan as part of your inpatient expense. The prescription medications benefit described here does not apply. All medications must be medically necessary to be covered.

7.6.1 Covered Medication Supply

These medications and supplies are covered when they have been prescribed for you:

a. A prescription medication that is medically necessary to treat a medical condition
b. Compounded medications that have at least one covered medication as the main ingredient
c. Insulin and diabetic supplies including insulin syringes, needles and lancets, test strips, glucometers and continuous glucose monitors. You must have a prescription and use a preferred manufacturer.
d. Certain prescribed preventive medications required under the Affordable Care Act
e. Medications to treat tobacco dependence, including OTC nicotine patches, gum or lozenges. You must have a prescription. If you use an in-network retail pharmacy, they are covered with no cost sharing as required under the Affordable Care Act
f. Contraceptive medications and devices for birth control (section 7.3.2) and for medical conditions covered under the Plan. You can get up to a 3-month supply the first time you use the medication and up to a 12-month supply after that. Ask Customer Service how to get a 12-month supply.
g. Certain immunizations and related administration fees are covered with no cost sharing at in-network retail pharmacies (such as flu, pneumonia and shingles vaccines).

Certain prescription medications and/or quantities of prescription medications may need to be prior authorized (see section 6.1). You must get specialty medications from a Moda-designated specialty pharmacy.

Ask Pharmacy Customer Service to help you coordinate your prescription refills, so you can pick them all up at the same time.

You can ask for a medication that is not on the formulary by having your professional provider submit an exception request or by contacting Customer Service. Formulary exceptions must be based on medical necessity. We will need your prescribing professional provider's contact information and information from your provider to support the medical necessity, including all of the following:

a. You tried the formulary medications, using the right dose and for a long enough time, and they did not work for you
b. You were not able to tolerate the formulary medications, or they were not effective for you
c. The formulary medications are expected to be harmful to you or not give the same result as the medication you are asking for
d. The medication treatment you are asking for is not experimental or investigational

We will contact your prescribing professional provider to find out how the medication is being used in your treatment plan. We will make a decision about your exception request within 72 hours – or just 24 hours if your request is urgent. This formulary exception process is not used for a medication or pharmacy charge that is not covered for other reasons, such as plan limitations or exclusions.

7.6.2 90-Day Supply at Participating Retail Pharmacies

You may buy a 90-day supply from participating retail pharmacies at the mail order cost sharing. Not all medications are eligible for a 90-day supply. All standard benefit and administrative provisions (such as prior authorization and step therapy) apply. Search for participating pharmacies using your Member Dashboard. Participating pharmacies will say "3 months" under the Days Supply column in their details.

7.6.3 Mail Order Pharmacy

You can choose to fill prescriptions for covered medications through a Moda-designated mail order pharmacy. Get a mail order pharmacy form on your Member Dashboard or ask Customer Service.

7.6.4 Specialty Services & Pharmacy

Specialty medications are often used to treat complex chronic health conditions. Your pharmacist and other professional providers will tell you if your prescription must be prior authorized or if you must get it from a Moda-designated specialty pharmacy. Find out about the clinical services and if your medication is a specialty medication on your Member Dashboard or by asking Customer Service.

Most specialty medications must be prior authorized. If you do not buy specialty medications at the Moda-designated specialty pharmacy, the expense will not be covered. Some specialty prescriptions may be limited to less than 30 days. Some medications may be eligible for a 90-day supply. For some specialty medications, you may have to enroll in a program to make sure you know how to use the medication correctly and/or to lower the cost of the medication. Get more information on your Member Dashboard or by asking Customer Service.

7.6.5 Self-Administered Medication

All self-administered medications follow all of the prescription medication requirements of section 7.6. This includes specialty medication requirements (section 7.6.4) when you get a self-administered specialty medication. Self-administered injectable medications are not covered if you get them in a provider's office, clinic or facility.

7.6.6 Step Therapy

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

We will make an exception to the step therapy requirement if:

a. The Step 1 medication is ineffective, harmful or you cannot tolerate it
b. The Step 1 medication is not giving the same result as the requested Step 2 medication
c. You tried a Step 2 medication for at least 90 days and had a positive outcome. Changing to the Step 1 medication is expected to be harmful or not give the same result

7.6.7 Limitations

a. New FDA approved medications will be reviewed. We may have coverage requirements or limits. You or your prescriber can ask for a medical necessity evaluation if we do not cover a newly approved medication during the review period
b. You will need a formulary exception to use a brand medication when a generic equivalent is available
c. We may prior authorize certain brand medications for a specific amount of time or until a generic medication becomes available, whichever comes first. When a generic medication becomes available during the authorized period, the brand medication is no longer covered. You can get the generic medication without a new prescription or authorization
d. You may not bypass the Plan's requirements (such as step therapy, prior authorization) by starting treatment with a medication, whether by using free samples or otherwise.
e. Some specialty medications may be limited to a 2-week supply
f. Medications with dosing intervals greater than the Plan's maximum day supply will have an increased copayment to match the day supply
g. Medications you buy outside the United States and its territories are only covered in emergency and urgent care situations
h. You may ask to have your medication refilled early if you are going to travel outside of the United States. When we allow an early refill, it is limited to once every 6 months. You cannot get an early refill to extend your medication supply beyond the end of the plan year
i. If you need an emergency refill of insulin or diabetic supplies, we will cover it no more than 3 times per year. We will only cover the smallest available package or a 30-day supply, whichever is less

7.6.8 Exclusions

In addition to the exclusions listed in Section 8, these medications and supplies are not covered:

a. **Devices.** Including, but not limited to therapeutic devices and appliances. Information for contraceptive devices is in section 7.6.1 and for other devices in section 7.4.12
b. **Foreign Medication Claims.** Medications you buy from non-U.S. mail order or online pharmacies or U.S. mail or online pharmacies acting as agents of non-U.S. pharmacies
c. **Hair Growth Medications.**
d. **Immunization Agents for Travel.** Except as required under the Affordable Care Act

e. **Institutional Medications.** To be taken by or administered while you are a patient in a hospital, rest home, skilled nursing facility, extended care facility, nursing home or similar institution
f. **Medication Administration.** A charge to administer or inject a medication, except for immunizations or contraceptives at retail pharmacies
g. **Medications Covered Under Another Benefit.** Such as medications covered under home health, medical, etc
h. **Medications Not Approved by FDA.** Products not recognized or designated as FDA approved medications. This includes medications that are found to be less than effective by the FDA's Drug Efficacy Study Implementation (DESI) classifications
i. **Non-Covered Condition.** A medication prescribed for reasons other than to treat a covered medical condition
j. **Nutritional Supplements and Medical Foods.**
k. **Off-label Use.** Medications prescribed for or used for non-FDA approved indications, unless Oregon's Health Evidence Review Commission or Pharmacy Therapeutics and Review Committee has approved it
l. **Over the Counter (OTC) Medications** and certain prescription medications that have an OTC option, except for contraceptives or those treating tobacco dependence
m. **Pharmacies Excluded from the Network.** Medications from pharmacies that have been excluded from the network for non-compliance with fraud, waste and abuse laws
n. **Repackaged Medications.**
o. **Replacement Medications and/or Supplies.**
p. **Vitamins and Minerals.** Except as required by law
q. **Weight Loss Medications**

7.6.9 Definitions

Brand Medications are medications sold under a trademark and protected name.

Formulary is a list of all prescription medications and how they are covered under the pharmacy prescription benefit. Use the prescription price check tool on your Member Dashboard to get coverage information, treatment options and price estimates.

Generic Medications are medications that have been found by the Food and Drug Administration (FDA) to be therapeutically equivalent to the brand option and will often save you money. Generic medications must have the same active ingredients as the brand version and be identical in strength, dosage form and the way you take them.

Nonpreferred Tier Medications are brand medications, including specialty brand medications, that we have reviewed and they do not have significant therapeutic advantage over their preferred alternative(s). These medications generally have safe and effective options available under the Value, Select and/or Preferred tiers.

Over the Counter (OTC) Medications are medications that you can buy without a professional provider's prescription. We consider a medication OTC as determined by the FDA.

Preferred Tier Medications are medications, including specialty preferred medications, that we have reviewed and found to be safe and effective at a better price compared to other medications in the same therapeutic class and/or category. Generic medications that have not been shown to be safer or more effective than other more cost effective generic medications are included in this tier.

Prescription Medication List Our Moda Health Prescription Medication List is on your Member Dashboard. It gives you information about how commonly prescribed medications are covered. Not every covered medication is on the list. We will review new medications and may set coverage limitations.

What tier a medication is in may change and will be updated from time to time. Use the prescription price check tool on your Member Dashboard to get the latest information. Ask Customer Service if you have any questions.

Prescribing and dispensing decisions are to be made by your professional provider and pharmacist using their expert judgment. Talk with your professional providers about whether a medication from the list is appropriate for you. This list is not meant to replace your professional provider's judgment when deciding what medication to prescribe to you. Moda Health is not responsible for any prescribing or dispensing decisions.

Prescription Medications include the notice "Caution - Federal law prohibits dispensing without prescription". You must have a prescription from your professional provider to get these medications.

Select Tier Medications are the most cost effective options in their therapeutic category. This tier includes generic and certain brand medications that are safe, effective and cost effective.

Self-Administered Medications are labeled by the FDA for self-administration. You or your caregiver can safely administer these medications to you outside of a medical setting (such as a physician's office, infusion center or hospital).

Specialty Medications Specialty medications are often used to treat complex chronic health conditions. Specialty medications often require special handling and have a unique ordering process. Most specialty medications must be prior authorized.

Value Tier Medications include commonly prescribed medications used to treat chronic medical conditions. They are considered safe, effective and cost-effective compared to other medication options. A list of value tier medications is on your Member Dashboard.

7.7 VISION CARE BENEFIT

7.7.1 Pediatric Vision Services

If you are under age 19, we cover these services once per year:

a. One complete eye exam, with refraction
b. Lenses and frames (glasses) to correct your vision, or contact lenses instead of glasses
c. Optional lenses and treatments include ultraviolet (UV) protective coating, scratch resistant coating, tinting, photosensitive lenses and polycarbonate lenses
d. Low vision services, including evaluation and low vision aids

You may see any licensed ophthalmologist or optometrist for these services. Glasses may also be provided by any licensed optician. When you choose in-network providers, it helps lower plan costs. Extra charges for special purpose vision aids or fashion features are not covered. This coverage ends at the end of the month in which you reach age 19.

7.7.2 Adult Vision Services

Vision exams and glasses (corrective lenses and frames) are covered if you are age 19 and over. There is an annual dollar maximum for all combined services. You may see any licensed ophthalmologist or optometrist for these services. Glasses may also be provided by any licensed optician. When you choose in-network providers it helps lower your costs.

We cover these services:

a. Complete eye exam, including refraction
b. Frames for corrective lenses
c. Corrective lenses for eyeglasses, or contact lenses

In addition to the exclusions listed in Section 8, these services and supplies are not covered:

a. Special procedures such as orthoptics and vision training
b. Nonprescription lenses
c. Medical or surgical treatment of the eyes. This includes medical eye examinations to manage diabetes. An annual dilated eye exam to manage diabetes is covered under the medical benefit (section 7.4.9).

SECTION 8. GENERAL EXCLUSIONS

This section lists Plan exclusions. These are in addition to the limitations and exclusions that are described in other sections. These services, supplies and conditions are not covered, even if they are medically necessary, are recommended or provided by a professional provider, or they relate to a covered condition. Treatment of a complication or consequence that happens because of an exclusion is not covered. Except, treatment of an emergency medical condition is always covered.

Benefits Not Stated
Services and supplies not included in this handbook as covered expenses, unless required under state or federal law.

Care Outside the United States
Except for care that is 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 9.4.1.3).

Correctional Services
Including sheltered living provided by a half-way house, education-only court ordered anger management classes, and court ordered sex offender treatment.

Cosmetic Procedures
Any procedure or medication with the main purpose of changing or maintaining your appearance and that will not result in significant improvement in body function. Examples include rhinoplasty, breast enhancement, liposuction and hair removal. Reconstructive or gender affirming surgery is covered if medically necessary and not specifically excluded (see section 7.4.32).

Custodial Care
Routine care and hospitalization that helps you with everyday life, such as bathing, dressing, getting in and out of bed, preparing special diets and helping you with medication that usually can be self-administered. Custodial care is care that can be provided by people without medical or paramedical skills.

Dental Examinations and Treatment; Orthodontia
Except services described in sections 7.4.8 and 7.4.22, or if medically necessary to restore function due to craniofacial irregularity.

Educational Supplies and Services
Including the following, unless provided as a medically necessary treatment for a covered medical condition:

a. Books, tapes, pamphlets, subscriptions, videos and computer programs (software)
b. Psychoanalysis or psychotherapy as part of a training or educational program, regardless of your diagnosis or symptoms
c. Educational services provided by a school, including a boarding school
d. Level 0.5 education-only programs

Experimental or Investigational Procedures
Expenses due to experimental or investigational procedures. Includes related expenses, even if they would be covered in other (non-experimental, non-investigational) situations (see definition of experimental/investigational in Section 12).

Faith Healing

Food Services
Including Meals on Wheels and similar programs, and guest meals in a hospital or skilled nursing facility.

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

Homeopathic Treatment and Supplies

Illegal Acts
Services and supplies to treat a medical condition caused by or arising directly from your illegal act.

Infertility
All services and supplies for office visits, diagnosis and treatment of infertility, as well as the cause of infertility. Includes surgery to reverse elective sterilization (vasectomy or tubal ligation).

Inmates
Services and supplies you get while you are in the custody of any state or federal law enforcement authorities or while in jail or prison, except when in an Oregon state or local facility and pending disposition of charges (waiting for your case to be resolved). Benefits paid under this exception may be limited to 115% of the Medicare allowable amount. Injuries under the Illegal Acts exclusion are not covered.

Massage or Massage Therapy

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

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

Non-Therapeutic Counseling
Including legal, financial, occupational and religious counseling.

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

Obesity or Weight Reduction
Even if you are morbidly obese. 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 change your eating behavior
c. Any medication or formula related to or resulting from the treatment of weight loss or obesity even if prescribed by a physician

The Plan covers services and supplies that are necessary to treat established medical conditions that may be caused by or made worse by obesity. 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 described in section 7.4.12.

Orthognathic Surgery
Including associated services and supplies. Except when medically necessary to repair an accidental injury or for treatment of cancer.

Personal Items
Including basic home first aid and things that can make you feel better but are not required medical treatment, necessities of living such as food and household supplies, and supportive environmental materials like. handrails, humidifiers, filters and other items that are not for treatment of a medical condition even if they relate to a condition that is otherwise covered.

Physical Exercise Programs
Programs, videos and exercise equipment.

Private Nursing Services

Professional Athletic Activities
Diagnosis, treatment and rehabilitation services for injuries you get while you are practicing for or participating in a professional or semi-professional athletic contest or event. These are events or activities you are paid or sponsored to do full-time or part-time.

Reports and Records
Including charges for completing claim forms or treatment plans.

Routine Foot Care
Including the following services unless your medical condition (such as diabetes) requires them:

a. Trimming or cutting of overgrown or thickened lesion (like a corn or callus)
b. Trimming of nails, regardless of condition

c. Removing dead tissue or foreign matter from nails

Self-Administered Medications
Including oral and self-injectable when you get them directly from a physician's office, facility or clinic instead of through the pharmacy prescription medication or anticancer benefits (sections 7.6.5 and 7.4.2).

Self-Improvement Programs
Psychological or lifestyle improvement programs including educational programs, retreats, assertiveness training, marathon group therapy, and sensitivity training unless they are a medically necessary treatment for a covered medical condition.

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

Services for Administrative or Qualification Purposes
Physical or mental examinations, psychological testing and evaluations and related services for purposes such as employment or licensing, participating in sports or other activities, insurance coverage, or deciding legal rights, administrative awards or benefits, or corrections or social service placement. The only exception is as specifically described in section 7.4.6.

Services Not Provided
Services or supplies you have not actually received. This includes missed appointments.

Services Otherwise Available
Someone else should have been responsible for the cost of these services or supplies. Examples include these situations:

a. You have not been charged or the charge has been reduced or discounted, or you would not normally be charged if you do not have insurance
b. Another third party has paid or is obligated to pay, or would have paid if you had applied for the program. This may include coverage under a separate contract that provides coordinated coverage and is considered part of the same plan. It could also be a government program (except Medicaid) or a hospital or program operated by a government agency or authority

This exclusion does not apply to covered services or supplies you get from a hospital owned or operated by the state of Oregon or any state approved community mental health and developmental disabilities program, or the Veterans' Administration of the United States if the care is not service related.

Services Provided or Ordered by a Family Member
Other than services by a dental provider. For the purpose of this exclusion, family members include you and your spouse or domestic partner, child, sibling, or parent, or your spouse's or domestic partner's parent.

Services Provided by Volunteer Workers

Sexual Dysfunction of Organic Origin
Services for sexual dysfunctions of organic origin, including impotence and decreased libido. Except medically necessary mental health services and supplies related to diagnoses listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders.

Support Groups
Including voluntary mutual support groups such as 12-step programs and family education or support groups, except as required under the Affordable Care Act.

Taxes, Fees and Interest
Except as required by law.

Telehealth
Except telemedicine as specifically described in section 7.4.36.

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

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

Third Party Liability Claims
Services and supplies to treat a medical condition that a third party is or may be responsible for, to the extent of any recovery received from or on behalf of the third party (see section 9.4.3).

Toupees, Hair Transplants

Transportation
Except medically necessary ambulance or secure transport as described in section 7.2.1.

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 who do not have an illness or a diagnosed behavioral health condition, or treatment of normal transitional response to stress.

Treatment After Coverage Ends
The only exceptions are:

a. You are hospitalized when the Plan ends and your services continue to meet the criteria for medical necessity (see section 10.5.1)
b. Covered hearing aids ordered before your coverage ends and you get them no more than 90 days after the end date

Treatment Before Coverage Begins
Including services and supplies for an admission to a hospital, skilled nursing facility or other facility that began before your coverage under the Plan began. We will provide coverage only for those covered expenses incurred on or after your effective date under the Plan.

Treatment Not Medically Necessary
Including services or supplies that do not meet our medical necessity criteria or are:

a. Prescribed for purposes other than treating disease
b. Inappropriate or inconsistent with the symptoms or diagnosis of your condition
c. Not established as the standard treatment by the medical community in the service area where you receive them
d. Primarily for your convenience or that of a provider
e. Not the least costly of the alternative supplies or levels of service that can be safely provided to you

If a service is not medically necessary to treat or diagnose your condition, it is not covered even if the condition is otherwise covered under the Plan. 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.

Vision Care
Except as described in section 7.7 or as otherwise covered under the Plan. This includes any charges for orthoptics, vitamin therapy, low vision therapy, eye exercises or fundus photography. See section 7.4.9 for coverage of annual dilated eye exam to manage diabetes.

Vision Surgery
Any procedure to cure or reduce near-sightedness, far-sightedness or astigmatism. Includes reversals or revisions, and treating any complications, of these procedures.

Vitamins and Minerals
Not covered unless required by law or if medically necessary to treat a specific medical condition. Coverage is only under the medical benefit. The vitamin or mineral must require a prescription, and a dosage form of equal or greater strength of the medication is not available without a prescription under federal law. This applies whether the vitamin or mineral is oral, injectable or transdermal. Naturopathic substances are not covered.

Work Related Conditions
Treatment of a medical condition you get because of your employment or self-employment, unless the expense is denied as not work related under any workers' compensation provision. You must file a claim for workers' compensation benefits and send us a copy of the workers' compensation denial letter to be eligible for payment under the Plan. This exclusion does not apply if you are an owner, partner or executive officer, if you are exempt from workers' compensation laws and the Group does not provide workers' compensation coverage to you.

SECTION 9. CLAIMS ADMINISTRATION & PAYMENT

9.1 SUBMISSION & PAYMENT OF CLAIMS

What to know about sending us a claim:

a. We must receive your claim no more than 12 months after the date of service
b. We do not always pay claims in the same order you received the services. This may affect how your cost sharing is applied to claims. For example, a deductible may not be applied to the first date you were seen in a benefit year if we pay a later date of service first
c. We will not pay any claims we do not receive on time. The only exceptions are Medicaid claims or absence of legal capacity. Claims from Medicaid must be sent to us no more than 3 years after the date of service.
d. We may pay benefits to you, to the provider or to both of you

The date of service is the date you receive the service or supply. You must actually receive the service or supply before we will pay the claim.

Usually, you can show your Moda Health ID card to the provider, and they will bill us for you. We will pay the provider and send a copy of our payment record to you. The provider will then bill you for any charges that were not covered.

9.1.1 How to Send Us Claims

Sometimes you will have to pay a provider up front. When you are billed by the hospital or professional provider directly, send us a copy of the bill (see section 2.1).

Include all of the following information:

a. Patient's name, subscriber's name, and group and ID numbers
b. Date of service
c. Diagnosis (including the ICD diagnosis codes)
d. Itemized description of the services and charges (including the CPT or HCPCS procedure codes)
e. Provider's tax ID number
f. Proof of payment. This can be a credit card/bank statement or cancelled check

Some claims will require additional information:

a. **Accidental injury**: Include the date, time, place and description of the accident
b. **Ambulance service**: Include where you were picked up and where you were taken
c. **Out-of-country care**: Only covered when you have an emergency or need urgent care. When you get care outside the United States, include:
    i. Explanation of where you were and why you needed care
    ii. Copy of the medical record (translated if available)

If any of the charges are covered by the Plan, we will reimburse you.

9.1.2 Prescription Medication Claims

When you go to an in-network pharmacy, show your Moda Health ID card and pay your prescription cost sharing. You will not have to file a claim.

If you fill a prescription at an out-of-network pharmacy that does not access our claims payment system, or buy an OTC contraceptive, you will need to fill out and send in the prescription medication claim form. This form is on your Member Dashboard. We will reimburse you for any covered charges.

9.1.3 Explanation of Benefits (EOB)

We will tell you how we processed a claim in a document called an Explanation of Benefits (EOB). We may pay claims, deny them, or apply the allowable expense toward satisfying any deductible. If all or part of a claim is denied, we will tell you why in the EOB. We encourage you to access your EOBs electronically by signing up through your Member Dashboard.

If you do not receive an EOB or an email telling you that an EOB is available within a few weeks of the date of service, this may mean that we did not receive the claim. Your claim will not be paid unless we receive it within the claim submission period explained in section 9.1.

9.1.4 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. We will respond to your inquiry within 30 days.

9.1.5 Time Frames for Processing Claims

You will hear from us no more than 30 days after we receive a claim.

a. If the claim is denied, we will send an EOB explaining the denial
b. If we need more time for reasons beyond our control, we will send you a notice of delay explaining those reasons. We will finish processing the claim no more than 45 days after we receive it
c. If we need more information, the notice of delay will describe the information we need. Whoever is responsible for providing the additional information will have 45 days to send it to us. We will finish processing the claim no more than 15 days after we get the additional information

We must receive all information we need to process your claim within the Plan's claim submission period explained in section 9.1.

If a service must be authorized, we will respond to the prior authorization request within 2 business days. If we ask for more information, we will finish the prior authorization request no more than 15 days after receiving the information. We will respond more quickly if you have an urgent medical condition.

9.2 COMPLAINTS, APPEALS & EXTERNAL REVIEW

Before you file an appeal, call Customer Service. We may be able to resolve your problem over the phone.

9.2.1 Time Limit for Submitting Appeals

If your appeals are not on time, you will lose the right to any appeal.

a. You have **180 days** from the date you receive an adverse benefit determination to send us your first level appeal
b. You have **60 days** from the date of the first level appeal decision to send us your second level appeal

You can fill out an appeal form (in your Member Dashboard under Resources), or send us a letter including all the identifying information from the appeal form (see "If I am not satisfied…" in section 13.1). Describe what happened and what outcome you are hoping for. Include medical records or other documentation that will help us investigate your appeal.

9.2.2 The Review Process

The Plan has a 2-level internal review process, a first level appeal and a second level appeal. If you are not satisfied with the result of the second level appeal, you may ask for external review by an independent review organization. You must finish the first and second levels of appeal before you can ask for external review, unless we agree to skip the internal reviews.

You may review the claim file and submit written comments, documents, records and other information to support your appeal. You may choose a person (representative) to act on your behalf. You must sign an authorization to disclose protected health information (PHI) allowing your representative to act for you. You may find this form on modahealth.com. Contact Customer Service for help assigning your representative.

How First and Second Level Appeals Work

a. Submit your appeal in writing, on time. If you need help, ask Customer Service
b. We will send you a letter no more than 7 days after we receive your appeal so you know we got it
c. Someone who was not involved in the original decision will investigate your appeal
d. We will send the decision to you within 15 days of a pre-service appeal or 30 days of a post-service appeal

If we use new or additional evidence or reasoning when deciding your second level appeal, we will share this with you. You may respond to this information before our decision (the final internal adverse benefit determination) is finalized.

Expedited Appeals

Appeals can have a faster review upon request. Review of appeals that meet the criteria to be expedited will be finished within 72 hours in total for the first and second level appeals combined after we have received those appeals. The time between the first level appeal decision and when we receive the second level appeal does not count.

If you do not provide enough information for us to make a decision, we will ask you and/or your provider for the information we need no more than 24 hours after we receive the appeal. We must get this information back as soon as possible. We will make a decision on an expedited appeal no more than 48 hours after the earlier of (a) our receipt of the information, or (b) the end of the time allowed to send us the information.

Special Circumstances

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

The timelines for reviewing your appeal do not apply if:

a. You do not reasonably cooperate

b. Circumstances beyond your control or ours make it impossible. Whoever is unable to meet a timeline must give notice of the specific reason to the other when the issue arises

If this is an ERISA plan, you must go through the first and second levels of appeal before you can sue under ERISA section 502(a). You may lose the right to sue if you have not used all of your internal appeal rights. The only exception is if we do not meet the timelines for review or provide all of the information and notices required under state and federal law. Ask your employer if this Plan is subject to ERISA.

9.2.3 External Review

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

a. The request for external review must be in writing to the Appeals Department (see section 2.1) no more than 180 days after you receive the final internal adverse benefit determination. If you need help with the request, ask Customer Service. You may submit additional information to the IRO within 5 days, or 24 hours for an expedited review.
b. You must have completed the appeal process described in section 9.2.2. We will send an appeal directly to external review if we both agree to skip this requirement. For an expedited appeal or when the appeal is about a condition for which you received emergency services and are still hospitalized, a request for external review may be expedited or at the same time as a request for internal appeal review.

Only certain types of denials are eligible for external review. The IRO screens requests, and will review appeals that relate to

a. An adverse determination based on a utilization review decision
b. Whether surprise billing protections apply to an adverse benefit determination
c. Whether the treatment is an active course of treatment for purposes of continuity of care (see section 9.3)
d. Rescission of coverage (section 10.5.6)
e. Cases in which we have not met the internal timeline for review or the federal requirements for providing related information and notices

The decision of the IRO is binding except to the extent other remedies are available to you under state or federal law. If we fail to comply with the decision, you have the right to sue.

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 you are a member under the Plan does not qualify for external review. A complaint decision does not qualify for external review.

9.2.4 Complaints

Submit your complaint in writing within 180 days from the date of the problem or claim. We will review complaints about:

a. Availability, delivery or quality of a health care service
b. Claims payment, handling or reimbursement for healthcare services that is not appealing an adverse benefit determination
c. The contractual relationship between us

We will finish reviewing your complaint within 30 days. If we need more time, we will send you a letter letting you know about the delay. We will have 15 more days to make a decision.

9.2.5 Definitions

For purposes of section 9.2, the following definitions apply:

Adverse Benefit Determination is a letter or an Explanation of Benefits (EOB) from us telling you that you are not eligible for benefits or that benefits have not been fully paid. Reasons are:

a. Rescission of coverage (section 10.5.6)
b. Eligibility to participate in the Plan
c. Network exclusion, annual benefit limit or other limitation on otherwise covered services
d. Utilization review (described below)
e. Limitations or exclusions described in Section 7 and Section 8, including a decision that an item or service is experimental or investigational or not medically necessary
f. Continuity of care (section 9.3) is denied because the course of treatment is not considered active

A **Final Internal Adverse Benefit Determination** is an adverse benefit determination that we have upheld at the end of the internal appeal process. The internal appeal process is finished.

Appeal is a written request by you or your representative for us to review an adverse benefit determination.

Complaint is an expression of dissatisfaction about a specific problem you have had or about a decision by us or someone acting for us or a provider. It includes a request to solve the problem or change the decision. Asking for information or clarification about the Plan is not a complaint.

Expedited appeal is aa pre-service appeal that needs a faster review because using the regular time period to review it could

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

Post-service appeal is an appeal about care or services that you have already received.

Pre-service appeal is an appeal about care or services that must be prior authorized and you have not had the services yet.

Utilization review is how we review the medical necessity, appropriateness or quality of medical care services and supplies. These adverse benefit determinations are examples of utilization review decisions:

a. The care is not medically necessary or appropriate
b. The care is investigational or experimental
c. The decision about whether a benefit is covered involved a medical judgment

9.3 CONTINUITY OF CARE

Sometimes a provider's contract with the network ends. On the day a provider's contract with us ends, they become an out-of-network provider. When this happens, we may cover some services

by the provider as if they were still in-network for a limited period of time. This is called continuity of care.

If you are under the care of a particular provider when their contract with us ends, you should get a letter from us or the provider group telling you about your right to continuity of care. If you ask for continuity of care before you get this letter, you are considered notified as of that date.

Continuity of care is not automatic. You must request continuity of care from us.

In addition:

a. Your provider must reasonably believe you have special circumstances that could cause you harm if you were to discontinue treatment with them
b. Your provider must agree to follow the requirements of their most recent medical services contract with us, and to accept the contractual reimbursement applicable at the time the contract ended

Special circumstances that make you eligible for continuity of care are:

a. Your care is an active course of treatment that is medically necessary. This includes pregnancy and institutional or inpatient care
b. You are being treated for a serious and complex condition. This may be a disability, chronic condition, or an acute or life-threatening illness
c. You are scheduled for a nonelective surgery. Both the surgery and the postoperative care are covered under this provision

Continuity of care ends on the earlier of the following dates for most members who are getting ongoing care from their provider:

a. The day after you finish the treatment or are no longer diagnosed with the condition that triggered your right to continuity of care
b. 90 days after the date you were told the contract with your provider had ended if your continuity of care is for inpatient or other facility care
c. 120 days after the date you were told the contract with your professional provider had ended if your continuity of care is for professional provider care

If you are receiving pregnancy care, continuity of care ends on the later of the following dates:

a. 45 days after your baby is born
b. Inpatient or facility care may be continued up to 90 days after the date you were told the contract with your provider had ended
c. If you continue active treatment, professional provider care may be continued not later than 120 days after the date you were told the contract with your professional provider had ended

Continuity of care is not available if:

a. You leave the Plan
b. The Group ends the Plan
c. The provider has moved out of the service area
d. The provider cannot continue to care for patients for other reasons
e. The contract with the provider ended for reasons related to quality of care and they have finished any appeals process

9.4 BENEFITS AVAILABLE FROM OTHER SOURCES

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

9.4.1 Coordination of Benefits (COB)

Coordination of benefits applies when you have healthcare coverage under more than one plan. If you are 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 Plan follows the order of benefit determination rules in the Oregon Administrative Rules. These rules decide which plan is primary and pays a claim for benefits first. (For coordination with Medicare, see section 9.4.2.)

COB can be very complicated. This is a summary of some of the more common situations where you may have double coverage. It is not a full description of all of the COB rules. If your situation is not described here, contact Customer Service for more information.

9.4.1.1 When this Plan Pays First

This Plan is primary and will pay first if the claim is for:

a. The subscriber's own healthcare expenses
b. Your covered child's expenses when you are the subscriber and
    i. Your birthday is earlier in the year than the other parent's and you are married, domestic partners or living together, or if there is a court decree assigning joint custody without specifying that one parent is responsible for healthcare expenses
    ii. You are separated, divorced or not living together and you have informed us of a court decree that makes you responsible for the child's healthcare expenses
    iii. You are separated, divorced or not living together. There is not a court decree, but you have custody of the child

If you are a covered child on this Plan and also covered by your spouse's or domestic partner's plan, the plan that has covered you the longest is primary.

9.4.1.2 How COB Works

When we are the primary plan, we will pay benefits as if there was not any other coverage.

If we are the secondary plan, the primary plan will pay its full benefits first. We will need a copy of your primary plan's EOB so we can see what they paid. If there are covered expenses that the primary plan has not paid, such as deductibles, copayments or coinsurance, we may pay some or all of those expenses.

a. We will calculate the benefits we would have paid if you did not have any other healthcare coverage. We will apply that amount to any allowable expense that the primary plan did not pay
b. We will credit any amount to the deductible that would have been applied if you did not have other coverage
c. We will reduce the benefits we pay so that payments from all plans are not more than 100% of the total allowable expense
d. If the primary plan did not cover an expense because you did not follow that plan's rules, we will not cover that expense either. An example is if your primary plan did not cover an expense because you did not get prior authorization when it was required

If the primary plan is a closed panel plan (HMO is an example) and you use an out-of-network provider, we will provide benefits as if we are the primary plan, except for emergency services or authorized referrals that are paid or provided by the primary plan.

Any plan that does not follow Oregon's COB rules is always primary.

9.4.1.3 Definitions

For purposes of section 9.4.1 the following definitions apply:

Plan is any of the following that provide benefits or services for medical or dental care or treatment:

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

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.

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 does not include:

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

Allowable expense is a healthcare expense, including cost sharing, that is covered at least in part by any plan you have coverage under. When a plan provides benefits in the form of a service instead of cash payments, the reasonable cash value of the service is considered an allowable expense and a benefit paid.

These are not allowable expenses:

a. Any expense that is not covered by any plan covering you
b. Any expense a provider is not allowed to charge you

9.4.2 Coordination with Medicare

We coordinate benefits with Medicare as required under federal law. This includes coordinating to the Medicare allowable amount. If the Plan is secondary to Medicare, we will not pay any expenses incurred from providers who have chosen not to participate in Medicare.

9.4.3 Third Party Liability

The rules for third party liability, including motor vehicle and other accidents, and surrogacy, are complicated and specific. We have included some high-level information here. Contact Customer Service for more information.

The Plan does not cover benefits when someone else - a third party - is legally responsible. This may include a person, a company or an insurer. Recovery from a third party may be difficult and take a long time, so we will pay your covered expenses based on your understanding and agreement that we are entitled to be reimbursed for any benefits paid that are or may be recoverable from a third party.

You agree to do whatever is necessary to fully secure and protect our right of recovery or subrogation. Subrogation refers to substituting one party for another in a legal setting. We are entitled to all subrogation rights and remedies under common and statutory law, as well as under the Plan. You will cooperate with us to protect our subrogation and recovery rights. This includes signing and delivering any documents we reasonably require to protect our rights and providing any information or taking actions that will help us recover costs from a third party.

a. If we pay claims that are, or are alleged to be, the responsibility of a third party, you hold any rights of recovery against the third party in trust for us.

b. We are entitled to be reimbursed for any benefits the Plan pays out of any recovery from a third party if there is a settlement or judgment against the third party. This is so whether or not the third party admits liability or claims that you are also at fault. We are entitled to receive the amount of benefits the Plan has paid whether the healthcare expenses are itemized or expressly excluded in the third party recovery.

c. If the Plan is subject to ERISA, it is not responsible for and will not pay any fees or costs (such as attorney fees) associated with your pursuing a claim against a third party. Neither the “made whole” rule nor the “common fund doctrine” rule applies. If the Plan is exempt from ERISA, a proportionate share of reasonable attorney fees may be subtracted from our recovery.

d. Even without your written authorization, we may release to, or obtain from, any other insurer, organization or person, any information we need to carry out the provisions of section 9.4.3.

e. If it is reasonable to expect that you will have future expenses for which the Plan might pay benefits, you will seek recovery of such future expenses in any third party claim.

f. Section 9.4.3 applies to you if the Plan advances benefits whether or not the event causing your injuries occurred before you became covered by Moda Health.

If you or your representatives do not comply with the requirements of this section, then we may not advance payment or may suspend payment of any benefits, or recover any benefits we have advanced, for any medical condition related to the third party claim except for claims related to motor vehicle accidents (see section 9.4.3.1). We may notify medical providers seeking payment that all payments have been suspended and may not be paid.

9.4.3.1 Motor Vehicle Accident Recovery

If you file a claim with us for healthcare expenses due to a motor vehicle accident and motor vehicle insurance has not yet paid, we will advance benefits. We have the right to be repaid from the proceeds of any settlement, judgement or other payment you receive that exceeds the amount that fully compensates you for your motor vehicle accident related injuries.

If we require you or your attorney to protect our recovery rights under this section, then you may subtract from the money to be paid back to the Plan a proportionate share of reasonable attorney fees as an expense for collecting from the other party.

You will do whatever is required to secure, and may not prejudice, our rights under this section.

9.4.4 Surrogacy

If you enter into a surrogacy agreement, you must reimburse the Plan for covered services related to conception, pregnancy, delivery and postpartum care that you receive in connection with the surrogacy agreement. By accepting services, you give us the right to receive payments you receive or are entitled to receive under the surrogacy agreement. Within 30 days after entering a surrogacy agreement, you must inform us and send us a copy of the agreement.

SECTION 10. ELIGIBILITY & ENROLLMENT

For coverage to become effective, you must submit an application on time. Any necessary premiums must also be paid.

10.1 SUBSCRIBER

You must give the Group a complete and signed application for yourself and any dependents to be enrolled within 31 days of becoming eligible to apply for coverage.

Your coverage begins on the date specified in the policy. This will be on your enrollment date or after a waiting period. To stay covered by the Plan, you must work the required hours. If your job changes, this could affect your eligibility.

You must tell us and the Group if your address changes.

10.2 DEPENDENTS

A subscriber's legal spouse or domestic partner (as defined in Section 12) is eligible for coverage. If a subscriber marries or enters a domestic partnership, the spouse or domestic partner and their children can enroll as of the date of the marriage or partnership. Coverage begins on the first day of the month after your application is received. See section 10.4 for more information.

A subscriber's children are eligible until their 26th birthday. The age limit applies even if a court or administrative order requires you to provide coverage after age 26.

In this Plan, eligible children are:

a. The biological or adopted child of the subscriber or the subscriber's eligible spouse or domestic partner
b. Children placed for adoption with the subscriber
c. Your newborn child for the first 31 days of the newborn's life
d. Children related to the subscriber and the subscriber is their legal guardian

Your newborn child is eligible from birth and coverage begins that day. A subscriber's adopted child or child placed for adoption is eligible on the date of placement. Their coverage begins on the date of adoption or placement. You must provide proof of legal guardianship to cover the subscriber's grandchild after the first 31 days from birth. See section 10.4 to add your new child.

Children with Disabilities
A subscriber's child who has a disability that makes them physically or mentally incapable of self-support is eligible for coverage even when they are over 26 years old. Submit written information from the child's physician showing that the child has an ongoing disability that does not allow them to work to support themself. To make sure there is not a gap in coverage, we need this information at least 45 days before their 26th birthday. We may ask for more information, such as tax and guardianship information, to confirm the child is eligible for this extended coverage. We will review eligibility from time to time unless the disability is permanent.

10.2.1 New Dependents

A new dependent may cause your premium to go up. Any premium changes will apply from the date coverage is effective. If you do not submit an application and/or payment when required, the new dependent will not be covered.

To add a new dependent to your coverage, submit:

a. Complete and signed application
b. Documentation. This may be a marriage certificate, domestic partnership documentation, birth certificate, or guardianship, adoption or placement for adoption paperwork

You must apply within 31 days of the new dependent becoming eligible. You need to inform us if you are adding or dropping family members from your coverage, even if it does not change your premiums.

10.3 OPEN ENROLLMENT

If you are not enrolled within 31 days of first becoming eligible, you must wait for the next open enrollment period to enroll unless:

a. You qualify for special enrollment as described in section 10.4
b. A court has ordered you to provide coverage for a spouse or minor child under the subscriber's health benefit plan. You must enroll no more than 30 days after the court order is issued

Open enrollment occurs once a year at renewal. If you enroll during open enrollment, coverage begins on the date the Plan renews.

10.4 SPECIAL ENROLLMENT

If you lose other coverage or become eligible for a premium assistance subsidy, you have special enrollment rights. Special enrollment applies to both the eligible employee and their dependent if neither is enrolled under 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 and supporting documentation within the required timeframe.

10.4.1 Loss of Other Coverage

If you do not enroll in the Plan when you are first eligible or at open enrollment because you have other health coverage, you may be able to enroll outside of the open enrollment period. You must meet all of the following criteria:

a. You stated in writing that you already had health coverage when this Plan was first offered to you
b. You ask to enroll no more than 31 days after your prior coverage ended
c. You have a qualifying event. These are:
    i. Your other coverage ended because you were no longer eligible. Examples of when this may happen include:
        A. loss of dependent status per plan terms, including divorce or legal separation
        B. end of employment or not working enough hours

C. the plan stops offering coverage to a specific group of similarly situated persons
D. moving out of an HMO service area and the plan does not have another option
E. the benefit package option is canceled, and no substitute option is offered

ii. You were covered under Medicaid or a children's health insurance program (CHIP) and the coverage ended due to loss of eligibility. You have up to 60 days after the end of coverage to enroll
iii. You exhausted your COBRA continuation coverage

Coverage begins on the first day of the month after the special enrollment request is received, or coinciding with, but not before, the loss of other coverage.

10.4.2 Payment Changes

You may have special enrollment rights when there are changes in how your premiums are paid:

a. Employer contributions toward your other active coverage (not COBRA coverage) ends. You must ask for special enrollment no more than 31 days after the contributions end.
b. If you are covered under Medicaid or CHIP and become eligible for a premium assistance subsidy, you may enroll in the Plan outside of the open enrollment period. You must ask for special enrollment no more than 60 days after becoming eligible.

Coverage begins on the first day of the month after the special enrollment request is received, or coinciding with, but not before, the premium contribution or subsidy change.

10.4.3 Gaining New Dependents

The employee has special enrollment rights if they are not enrolled at the time of the event that caused them to gain a new dependent (such as marriage, domestic partnership, birth, adoption or placement for adoption). You can enroll along with your new dependent. See section 10.2.1.

10.4.4 Qualified Medical Child Support Order (QMCSO)

The child of an eligible employee may have a right to enroll because of a qualified medical child support order (QMCSO). You may get a copy of the detailed procedures used to decide if an order qualifies as a QMCSO from the Group at no cost. Coverage begins on the first day of the month after the date the Group decides the order qualifies as a QMCSO and that the child is eligible to enroll in the Plan.

10.5 WHEN COVERAGE ENDS

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

10.5.1 The Group Plan Ends

Coverage ends for the Group as a whole and members on the date the Plan ends. There is one exception to this rule. If the Group ends the Plan and immediately replaces it with a policy through another carrier, and you are hospitalized on the day the Plan coverage ends, your coverage under the Plan continues until you are discharged from the hospital if your stay meets medical necessity criteria.

If the policy is ended and the Group does not replace it, the Group will tell you about your rights to continuation coverage under federal and/or state law.

10.5.2 Subscriber Ends Coverage

A subscriber may end their coverage, or coverage for any enrolled dependent, only at open enrollment or if there is a qualifying event. Qualifying events include marriage, divorce and birth. Coverage ends on the last day of the month through which premiums are paid.

10.5.3 Death

If a subscriber dies, coverage for any enrolled dependents ends on the last day of that month. You may extend your coverage if you meet the requirements for continuation of coverage (see Section 11). The Group must tell us your coverage is continued, and include your continuation premiums along with their regular monthly payment.

10.5.4 Termination, Layoff or Reduction in Hours of Employment

When the subscriber's employment ends, coverage ends on the last day of that month, unless you choose to continue coverage (see Section 11).

If you are laid off work or your hours are reduced, coverage ends on the last day of the month you were eligible. You can restart your coverage as if it had never ended if you are back at work and working the required hours within 9 months. Coverage will restart on the date you meet the eligibility requirements.

a. You will not have to re-serve a waiting period
b. The Group must notify us that you have been rehired following a layoff or that your hours have been increased
c. Your premiums must be paid

10.5.5 Loss of Eligibility by Dependent

Coverage ends on the last day of the month in which the dependent's eligibility ends.

a. Coverage ends for an enrolled spouse or domestic partner on the last day of the month in which the marriage or partnership is legally ended (divorce, dissolution, annulment, etc.)
b. Coverage ends for an enrolled child on the last day of the month in which
    i. the child reaches age 26
    ii. stepchild relationship ends due to divorce or end of domestic partnership
    iii. legal guardianship ends

You must tell us when a marriage, domestic partnership or guardianship ends.

Enrolled dependents may have the right to continue coverage in their own names when their coverage under the Plan ends (see Section 11).

10.5.6 Rescission

Rescission means cancelling (rescinding) coverage back to the effective date, as if it had not existed. We may rescind your coverage, or deny claims at any time, for fraud or intentional material misrepresentation by you or the Group.

Examples of fraud and material misrepresentation include but are not limited to:

a. Enrolling someone who is not eligible
b. Giving false information or withholding information that is the basis for eligibility or employment
c. Submitting false or altered claims

We have the right to keep any premiums paid as liquidated damages. You and/or the Group will have to repay any benefits that have been paid. We will tell you of a rescission 30 days before your coverage is canceled.

10.6 ELIGIBILITY AUDIT

We have the right to make sure you are eligible. We may ask for documentation including but not limited member birth certificates, adoption paperwork, marriage or domestic partnership documentation and any other evidence necessary to document your eligibility for the Plan.

SECTION 11. CONTINUATION OF HEALTH COVERAGE

Check with the Group to find out if you qualify for continuation coverage. You should read the following sections carefully.

11.1 GENERAL OREGON CONTINUATION

General Oregon Continuation applies to employers who are not required to offer COBRA continuation.

You may request General Oregon Continuation coverage if you lose coverage due to one of the following qualifying events:

a. Subscriber's employment ends or their work hours are reduced
b. Subscriber becomes eligible for Medicare
c. Subscriber dies or marriage/domestic partnership with the subscriber ends
d. Child no longer qualifies as an eligible child under the Plan

You must have been enrolled on the Plan for at least 3 consecutive months before the date of the qualifying event. You cannot be eligible for Medicare or for any other hospital or medical benefits that are not already covering you when the subscriber's employment ended. If you are eligible for 55+ Oregon continuation coverage (see section 11.2), you cannot elect General Oregon Continuation.

You must ask for continuation coverage in writing no more than 10 business days after you receive notice of your continuation rights or after the date of the qualifying event, whichever is later. If you do not ask for General Oregon Continuation on time, or pay your first premium within 31 days of the date coverage normally would have ended, your coverage under the Plan will end.

General Oregon Continuation will end if we do not receive your premiums on time or if the Plan as a whole ends. Otherwise, coverage ends on the earliest of the following events:

a. 9 months after the date on which coverage under the Plan otherwise would have ended
b. You become eligible for Medicare
c. You give us written notice that you want to end your coverage
d. If you are a dependent, the last day of the month in which you would normally lose eligibility under the terms of the Plan

11.2 55+ OREGON CONTINUATION

55+ Oregon Continuation applies to employers with 20 or more employees. It provides continuation coverage for spouses and domestic partners age 55 and older who are not eligible for Medicare. If you lose coverage because the subscriber died or your marriage or domestic partnership with the subscriber ended, you may elect 55+ Oregon Continuation coverage for yourself and any enrolled dependents if you meet all the requirements.

You must notify the Group or its third party administrator within 60 days from the date your marriage or domestic partnership is legally ended or 30 days after the subscriber has died. Include your mailing address. You will be given information about how to sign up for continuation

coverage and pay premiums. If you do not elect 55+ Continuation on time, you will lose the right to this continuation coverage.

Your coverage will end if you do not pay on time, or if the Plan as a whole ends. Otherwise, 55+ Oregon Continuation ends when you become insured under any other group health plan, you become eligible for Medicare, or you remarry or register another domestic partnership.

If the Group or its third party administrator does not notify you of your continuation rights, the Group is responsible for premiums from the date the notice was required until the date you receive the notice.

11.3 COBRA CONTINUATION COVERAGE

COBRA continuation coverage does not apply to all groups. Check with the Group to find out if this Plan qualifies. In this COBRA section, COBRA Administrator means either the Group or the third party administrator they have assigned to handle COBRA administration. Your coverage under COBRA continuation will be the same as that for other members under the Plan.

You may elect COBRA if you are the subscriber and you lose coverage because your employment ended (other than for gross misconduct), or your hours are reduced.

Be sure to look at *Special Circumstances at the end of the COBRA section.

If you are the spouse or child of the subscriber, COBRA is available if you lose coverage because of:

a. The subscriber's death
b. The subscriber's employment ends (other than for gross misconduct) or their hours of employment with the Group are reduced
c. The subscriber becomes entitled to Medicare
d. Divorce or legal separation from the subscriber*
e. You no longer meet the definition of "child" under the Plan

You must provide written notice to the COBRA Administrator if one of these events occurs. Include: 1) the name of the Group; 2) the name and social security number of the affected members; 3) the event (such as divorce); and 4) the date the event occurred. You must give notice no later than 60 days after you lose coverage under the Plan. If notice of the event is not given on time, COBRA is not available.

Electing COBRA. You must elect COBRA within 60 days after plan coverage ends, or, if later, 60 days after the COBRA Administrator sends you notice of your right to elect COBRA. Each family member* has an independent right to elect COBRA coverage. This means that a spouse or child may elect COBRA even if the subscriber does not.

You are responsible for all COBRA premiums. Due to the 60-day election period, you will owe retroactive premiums for the months between when regular coverage ended and the first payment date. You must pay these premiums in a lump sum at the first payment. The first payment is due within 45 days after you elect coverage (this is the date the election notice is postmarked, if mailed, or the date the COBRA Administrator receives it, if hand-delivered). The premium rate may include a 2% add-on to cover administrative expenses.

All other payments are due on the 1st of the month. You will not receive a bill. You are responsible for paying your premiums when due. If your premiums are not received on time, your COBRA coverage will end and may not be reinstated. You will have a 30-day grace period to pay the premiums.

Length of COBRA
COBRA due to end of employment or a reduction of hours of employment generally lasts up to 18 months. COBRA because of a subscriber's death, divorce or legal separation, or a child ceasing to be a dependent under the terms of the Plan, can last up to a total of 36 months.

If the subscriber became entitled to Medicare less than 18 months before their employment ends or their hours are reduced, COBRA for members (other than the subscriber) who lose coverage because of the employment end/reduction in hours can last up to 36 months after the date of Medicare entitlement.

You and your family may be eligible for a longer period of COBRA coverage if you are disabled or a second qualifying event occurs. You must notify the COBRA Administrator within 60 days of a second qualifying event or becoming disabled. If you do not, you will lose the right to extended COBRA coverage.

If the Social Security Administration determines you are disabled, your 18-month COBRA period may be extended to a total of up to 29 months. The disability must have started before the 61st day of your COBRA coverage period. The Social Security Administration must make its decision before the end of your initial 18-month COBRA period. You must give a copy of the Social Security Administration's determination of disability to the COBRA Administrator no more than 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 you lose (or would lose) coverage under the terms of the Plan as a result of the subscriber's termination or reduction of hours of employment

Each family member on COBRA can have the disability extension if one of you qualifies. Your COBRA premiums may increase after the 18th month of coverage to 150% of the premiums. Your disability extension ends if you are no longer considered disabled.

If you are a spouse or child on COBRA and a second qualifying event occurs, your maximum COBRA period may be extended to 36 months from the date of the first qualifying event. Second qualifying events may include the death of the subscriber, divorce or legal separation from the

subscriber, or a child's no longer being eligible as a dependent under the Plan. These are a second qualifying event only if they would have caused you to lose coverage if the first qualifying event had not occurred.

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 11.2).

When COBRA Ends
COBRA coverage ends after the maximum COBRA period. It will end earlier if your premiums are not paid on time or the Group stops offering any group health plan to its employees. COBRA will also end if:

a. You become covered under another group health plan
b. You become entitled to Medicare benefits after electing COBRA (unless the qualifying event is the Group's bankruptcy)
c. Any reason the Plan would end coverage if you were not on COBRA (such as fraud)

Ask the COBRA Administrator if you have any questions about COBRA. Don't forget to tell the COBRA Administrator if your address changes.

***Special Circumstances**
A domestic partner does not have an independent election right under COBRA. If you are a covered domestic partner at the time of the qualifying event, the subscriber can include coverage for you when they elect COBRA. Your coverage ends when the subscriber's COBRA coverage ends (for example, due to the subscriber's death or because the subscriber becomes covered under another plan).

Divorce or legal separation may be a qualifying event even if the subscriber ended your coverage earlier. If you notify the COBRA Administrator within 60 days of the divorce or legal separation, COBRA may be available for the period after the divorce or legal separation.

If the Plan provides retiree coverage and the subscriber's former employer files for bankruptcy, this may be a qualifying event if you lose coverage as a result. Contact the COBRA Administrator for more information about this situation.

11.4 UNIFORMED SERVICES EMPLOYMENT & REEMPLOYMENT RIGHTS ACT (USERRA)

If the subscriber is called to active duty by any of the armed forces of the United States of America, they may continue coverage under USERRA for up to 24 months or the period of uniformed service leave, whichever is shortest. You must continue to pay your share of the premiums during the leave. If you do not elect continued coverage under USERRA, or you cancel or use up your USERRA continuation, coverage restarts on the day you return to active employment with the Group. All plan provisions and limitations apply as if your Plan coverage had been continuous. You must be released under honorable conditions, and return to active employment within the required timeframe. You can get complete information about your rights under USERRA from the Group.

11.5 FAMILY & MEDICAL LEAVE

You will remain eligible for coverage during a leave of absence under state or federal family and medical leave laws. If you choose not to stay enrolled, you will be eligible to re-enroll in the Plan on the date the subscriber returns to work. Submit a complete and signed application within 60 days of the return to work. Your coverage will re-start as if there had been no break in coverage.

11.6 WORKERS' COMPENSATION

If you have a work-related medical condition and are not working enough hours to be eligible because of it, you may continue your coverage for up to 6 months. You must have filed a workers' compensation claim. You must pay the full premiums to the Group. The Group must pay the premiums to us when due. This continuation happens at the same time as any family medical leave. You can elect other continuation of coverage after the end of this continuation. Your workers' compensation continuation will end early if you become employed full-time with another employer.

11.7 STRIKE OR LOCKOUT

If you are employed under a collective bargaining agreement and involved in a work stoppage because of a strike or lockout, you must pay the full premiums, including any part usually paid by the Group, to the union or trust. The union or trust must send the premiums to us 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. You become employed full-time with another employer
c. You lose eligibility under the Plan for other reasons

SECTION 12. DEFINITIONS

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

Authorization see Prior Authorization.

Balance Billing is the difference between the maximum plan allowance (MPA) and the provider's billed charge. You will have to pay this amount when you choose to use an out-of-network provider. You cannot be balance billed if an out-of-network provider is performing services at an in-network facility and you did not choose the provider, or when otherwise prohibited by law. Balance billing is not a covered expense under the Plan.

Behavioral Health refers to mental health and/or substance use disorder and the services to treat these conditions.

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

Coinsurance is a percentage of covered expense that you pay. If your coinsurance is 20%, you pay 20% of the covered charge and we pay the other 80%.

Copay or **Copayment** is a fixed dollar amount you pay to a provider when you get a covered service. For example, you may have a $25 copay every time you see your primary care physician. This would be all you pay for the office visit (but other services you get at the same time may have other cost sharing).

Cost Sharing is the share of costs you must pay when you get a covered service. It includes 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 you conduct common activities such as bathing, eating, dressing, getting in and out of bed, preparation of special diets and supervision of medication that usually can be self-administered. It is care that can be provided by people without medical or paramedical skills.

Deductible is the amount of covered expenses you must pay before the Plan starts paying. If you get services from both in-network and out-of-network providers, 2 separate deductibles may apply.

Dental Care is services or supplies to prevent, diagnose or treat diseases of the teeth and supporting tissues or structures such as your gums. It includes services or supplies to restore your ability to chew and to repair defects that have developed because of tooth loss.

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

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

Eligible Employee is an employee of the Group who meets the eligibility requirements to be enrolled on the Plan (see section 10.1).

Emergency Medical Condition is a medical condition or behavioral health crisis with acute symptoms, including severe pain, that a prudent layperson with an average knowledge of health and medicine could reasonably expect would place the health or mental health of a member, or a fetus in the case of a pregnant member, in serious jeopardy without immediate medical or behavioral health attention. A behavioral health crisis is a disruption in a person's mental or emotional stability or functioning resulting in an urgent need for immediate outpatient treatment in an emergency department or admission to a hospital to prevent a serious deterioration in the person's mental or physical health.

Emergency Medical Screening Examination is the medical history, examination (which may include behavioral health assessment), related tests and medical determinations required to confirm the nature and extent of an emergency medical condition. A behavioral health assessment is an evaluation by a behavioral health provider, in person or using telemedicine, to determine a person's need for immediate crisis stabilization.

Emergency Services are emergency medical services transport as well as healthcare items and services you get in an emergency department of a hospital. All related services routinely available to the emergency department to the extent they are required to stabilize a member, and further medical examination and treatment required to stabilize a member and within the capabilities of the staff and facilities available at the hospital, are included.

At an out-of-network emergency care facility, emergency services may also include post-stabilization services such as outpatient observation or an inpatient or outpatient stay, unless the attending physician determines you are able to travel using nonmedical or nonemergency medical transportation to an in-network facility. If you are able to travel and you give informed consent for out-of-network care according to state and federal requirements, then post-stabilization services are not emergency services

Enroll means to become covered for benefits under the Plan. You are enrolled when your coverage becomes effective, not at the time you have completed or filed any enrollment forms needed to become covered. You are enrolled in the Plan whether you elect coverage, you are a dependent who becomes covered as a result of an election by the subscriber, or you become covered without an election.

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

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

a. Involve a treatment for which scientific or medical assessment has not been completed, or the effectiveness of the treatment has not been generally established. This includes a treatment program that may be proven for some uses, but scientific literature does not support the use as requested or prescribed. An example is a medication that is proven as

a treatment when used alone, but scientific literature does not support using it in combination with other therapies

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

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

Health Benefit Plan is 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. This Plan is a health benefit plan.

Illness is a disease or bodily disorder that results in a covered service.

Implant is a material inserted or grafted into tissue.

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

In-network refers to providers contracted under one of our approved networks to provide care to you.

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

MPA for out-of-network services is either a supplemental provider fee arrangement we may have in place or the amount calculated using any one of the following methods: a percentage of the Medicare allowable amount, a percentage of the allowable amount established by the Oregon Health Authority, a percentile of fees commonly charged for a given procedure in a given area, a percentage of the acquisition cost or a percentage of the billed charge.

MPA for emergency services you get out-of-network, out-of-network air ambulance, or out-of-network services in an in-network facility where you are not able to choose the provider is based on the median in-network rate. Otherwise, the MPA is the amount determined by state guidelines.

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

In certain instances, when a dollar amount is not available, we review the claim to determine a comparable code to the one billed. The claim is processed using the comparable code and as described above.

When you use an out-of-network provider, you may have to pay any amount over the MPA (this is the balance billing amount) except when balance billing is prohibited by law.

Medical Condition is any physical or mental condition, including one resulting from illness, injury (whether or not the injury is accidental), pregnancy or birth defect. Genetic information in and of itself is not a condition. Genetic information is information related to you or your relative about genetic tests, a request for or receipt of genetic services, or participation in clinical research that includes genetic services. It also includes a relative's disease or disorder.

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

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

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

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

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

Medically necessary care does not include custodial care. See Treatment Not Medically Necessary in the General Exclusions (Section 8) for more information.

Member is a subscriber or dependent of the subscriber who is enrolled for coverage under the terms of the Plan. Where this book refers to "you" or "your" it is referring to a member.

Mental Health Provider is any of the following state-licensed professionals:

a. Board-certified psychiatrist
b. Psychologist or psychologist associate
c. Psychiatric mental health nurse practitioner
d. Clinical social worker, mental health counselor or marriage and family therapist
e. A program licensed, approved, established, maintained, contracted with or operated by the Oregon Office of Mental Health & Addiction Services
f. An associate or resident in the field of counseling, marriage and family therapy, social work or psychology who is practicing under a board-approved supervision plan and working for a provider who is contracted and credentialed with Moda Health

Moda Health refers to Moda Health Plan, Inc. Where this book refers to “we”, “us” or “our” it is referring to Moda Health or its employees.

Network is a group of providers who contract to provide healthcare to you at negotiated rates. These groups are called Preferred Provider Organizations (PPOs), and provide in-network services in their specific service areas. See Section 5 for more information about networks. Covered medical expenses are paid at a higher rate when an in-network provider is used, as shown in Section 3.

Out-of-network refers to providers that are not contracted under one of our approved networks to charge discounted rates to you.

Out-of-Pocket Maximum is the maximum amount you pay out-of-pocket every year. It includes the deductible, coinsurance and copays. If you get services both in-network and out-of-network, 2 separate out-of-pocket maximums may apply. If you reach the out-of-pocket maximum in a calendar year, the Plan will pay 100% of your eligible expenses for the rest of the year.

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.

Plan Year is the 12 month period starting on the original effective date and each 12 month period afterward.

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 getting approval from us before the date of service. A complete list of services and medications that require prior authorization is available on your Member Dashboard or you can ask Customer Service. A service, supply or medication that is not prior authorized when required will not be covered (see section 6.1).

Professional Provider is any state-licensed or state-certified healthcare professional, when providing medically necessary services within the scope of their license or certification.

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

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

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

Waiting Period is the period that must pass before you are eligible to enroll for benefits under the terms of the Plan.

SECTION 13. GENERAL PROVISONS & LEGAL NOTICES

13.1 MEMBER DISCLOSURES

What are my rights and responsibilities as a Moda Health member?
You have the right to:

a. Information about the Plan and how to use it, the providers who will care for you, and your rights and responsibilities
b. Be treated with respect and dignity
c. Urgent and emergency services, 24 hours a day, 7 days a week
d. Participate in decision making regarding your healthcare. This includes
    i. changing to a new primary care physician (PCP)
    ii. a discussion of appropriate or medically necessary treatment options, no matter how much they cost or if they are covered
    iii. the right to refuse treatment and be informed of the possible medical result
    iv. filing a statement of wishes for treatment (i.e., an Advanced Directive), or giving someone else the right to make healthcare choices for you when you are unable to (Power of Attorney)
e. Privacy. Personal and medical information will only be used or shared as required or allowed by state and federal law
f. Appeal a decision or file a complaint about the Plan, and to receive a timely response.
g. Free language assistance services when communicating with us
h. Make suggestions regarding our member rights and responsibilities policy

You have the responsibility to:

a. Read this handbook and make sure you understand the Plan. You should call Customer Service if you have any questions
b. Select a PCP and tell us who you have chosen
c. To the extent required by the Plan, seek medical services only from your PCP. This includes getting approval from your PCP before going to a specialist
d. Treat all providers and their staff with courtesy and respect
e. Be on time for appointments, and call the office ahead of time if you will be late or need to cancel.
f. Get regular health checkups and preventive services
g. Give your provider all the information they need to provide good healthcare to you
h. Participate in making decisions about your medical care and forming a treatment plan
i. Follow plans and instructions for care you have agreed to with your provider
j. Use urgent and emergency services appropriately
k. Show your medical ID card when seeking medical care
l. Tell providers about any other insurance policies that may provide coverage
m. Reimburse us from any third party payments you may receive
n. Provide information we need to properly administer benefits and resolve any issues or concerns that may arise

More information about your rights and responsibilities is below. You may also call Customer Service with any questions.

The Plan requires a PCP to coordinate all healthcare needs. How do I know when I need a referral?
You do not need a referral. When medically necessary, your PCP will direct you to an in-network provider for specialized care or services.

Will someone tell me if my PCP is no longer participating in the network?
If your PCP ends their participation in the network, we will tell you and give you instructions on how to change your PCP.

What if I have a medical emergency?
If you believe you have a medical emergency, call 911 or seek care from the nearest appropriate provider, such as a physician's office or clinic, urgent care facility or emergency room.

You do not need to contact your PCP before you get emergency treatment. You should contact your PCP as soon as reasonably possible afterward. You are covered anywhere in the world for medical emergency treatment. More information is in section 7.2.

How will I know if my benefits change or end?
The Group will notify you if your benefits change or your coverage is terminated. If the policy ends 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.

What are the prior authorization and utilization review criteria?
Getting prior authorization is your assurance that the services and supplies recommended by your provider are medically necessary and covered under the Plan. You may contact Customer Service or visit your Member Dashboard for a list of services that require prior authorization.

Except in the case of fraud or misrepresentation, prior authorization for benefit coverage and medical necessity is binding for 60 days, and eligibility is binding for 5 business days from the date of the authorization.

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

You can get a written summary of information that may be included in our utilization review of a particular condition or disease by calling Customer Service.

What are my rights under the Women's Health and Cancer Rights Act of 1998 (WHCRA)?
You have benefits for mastectomy related services. This includes all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses and complications resulting from a mastectomy, including lymphedema. Contact Customer Service for more information.

How are important documents, such as my medical records, kept confidential?
We protect your information in several ways:

a. We have a written policy to protect the confidentiality of health information
b. Only employees who need to access your information 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

If I am not satisfied with the Plan, how can I file an appeal or complaint?
You can file an appeal or complaint by writing a letter to Moda Health. Include the following information:

a. Member name and date of birth
b. Subscriber ID number
c. Contact information (phone, email, mailing address)
d. Provider(s) involved
e. Date(s) of service
f. Medical records from the provider, if applicable
g. Reason for appeal/complaint
h. Description of what happened
i. Desired outcome

Customer Service can help you if needed. Complete information about the appeal process is in section 9.2.

You may also file a complaint or ask for help from the Oregon Division of Financial Regulation:

Phone: 503-947-7984 or toll-free 888-877-4894
Mail: PO Box 14480, Salem, Oregon 97309-0405
Website: dfr.oregon.gov
email: DFR.InsuranceHelp@oregon.gov

How can non-English speaking members get information about the Plan?
Customer Service will coordinate the services of an interpreter over the phone when they call.

How can I participate in the development of your corporate policies and practices?
We welcome any suggestions to improve our health benefit plans or services. We have advisory committees to allow participation in the development of corporate policies and to provide feedback. You may contact us for more information.

What is provider risk sharing?
This plan includes risk sharing arrangements with some providers. Under a risk-sharing arrangement, providers are subject to some financial risk or reward for the services they deliver. Contact us for more information.

What additional information about Moda Health is available?
These documents are available free of charge by calling Customer Service:

a. Our annual report on complaints, appeals and prior authorizations
b. Our 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 your care
d. Prior authorization and utilization review procedures

The following information about our health benefit plans is available from the Oregon Division of Financial Regulation:

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

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

Contact:
Oregon Division of Financial Regulation
PO Box 14480, Salem, Oregon 97309-0405
503-947-7984 or toll-free 888-877-4894
dfr.oregon.gov
DFR.InsuranceHelp@oregon.gov

13.2 GENERAL & MISCELLANEOUS

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.

Confidentiality of Member Information
Keeping your protected health information (PHI) confidential is very important to us. PHI includes enrollment, claims, and medical and dental information. We use this information to pay your claims and authorize services. It is also used for referrals, case management and quality management programs. We do not sell your information. The Notice of Privacy Practices has more detail about how we use your PHI. Follow the Privacy Center link on the Moda Health website for a copy of the notice, or call 855-425-4192.

Right to Collect & Release Needed Information
You must give us, or authorize a provider to give us, any information we need to pay benefits. We may release to or collect from any person or organization any needed information about you.

Transfer of Benefits
Only members are entitled to benefits under the Plan. These benefits are not assignable or transferable to anyone else except to the provider.

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

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.

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.

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 we delay or fail 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.

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

Responsibility for Quality of Medical Care
You always have the right to choose your provider. We are not responsible for the quality of your medical care. Your providers act as independent contractors. We cannot be held liable for any injuries you get while receiving medical services or supplies.

Compliance with Federal & 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 and coverage of essential health benefits as defined by the Affordable Care Act, except that the Plan does not provide the required pediatric dental coverage. The Group must have a Marketplace certified pediatric dental plan available for their members.

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.

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.

Time Limit 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 9.1). All internal levels of appeal under the Plan must be exhausted before filing a legal action in court.

Evaluation of New Technology
Moda Health develops medical necessity criteria for new technologies and new use of current technologies. The medical necessity criteria 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.

Replacing Another Plan
If this Plan replaces an existing policy or a group plan from another insurance company, the following applies:

a. If you are hospitalized on the date this Plan becomes effective, we will reduce this Plan's benefits by an amount paid or payable by your prior plan. This applies until you are discharged from the hospital or the hospital benefits are exhausted, whichever comes first
b. We will credit any deductible amounts you satisfied under your prior plan toward this Plan's deductibles
c. You will give us information we need about the terms of your prior plan and any claim payments your prior plan made

Notices
Any notice to you, to a provider or to the Group that we are required to provide is considered properly given if written notice is deposited in the U.S. mail or with a private carrier. Notices will be addressed to the last known address in our records. If we receive a U.S. Postal Service change of address form, we will update our records with that new address. We may forward a notice for you to the Group if we become aware that we do not have a valid mailing address for you. Any notice you are required to send to us may be mailed to our Customer Service address. Notice to us is not considered given to us and received by us until we have physically received it.

13.3 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). Ask the Group if this section applies to your Plan.

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.

Information About the Plan and Benefits
Subscribers may examine all documents governing the Plan. This includes insurance contracts, collective bargaining agreements, updated summary plan description, and the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor (if any). This information can be obtained by written request. You will not be charged, except the Group may charge a reasonable amount for the copies. Subscribers are entitled to receive a summary of the Plan's annual financial report, if any is required by ERISA.

Continuation of Group Health Plan Coverage
Subscribers are entitled to continue healthcare coverage for themselves or their dependents if they lose coverage under the Plan because of a qualifying event. You may have to pay for such coverage. Review this handbook and the documents governing the Plan for information about the rules governing your continuation coverage rights.

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 them from obtaining a benefit or exercising rights under ERISA.

Enforcement of Rights
If a claim for benefits is denied or no action is taken, in whole or in part, you 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 you can take to enforce these rights. For instance, if you ask the Group for a copy of plan documents or the latest annual report and do not receive it within 30 days, you may file suit in federal court. The court may require the Group to provide the materials and pay you up to $110 a day until you receive 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, you may file suit in state or federal court after you have exhausted the Plan's appeal process (see section 9.2). In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court.

If plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you 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 you are successful, the court may order the person you sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, (e.g., if it finds the claim is frivolous).

Assistance with Questions
For questions about this section or your rights under ERISA, or for help obtaining documents from the Group, contact one of the following:

Employee Benefits Security Administration
Seattle District Office, 300 Fifth Ave., Ste. 1110, Seattle, WA, 98104
Phone 206-757-6781
Information and assistance is also available through their website: dol.gov/agencies/ebsa

Office of Outreach, Education and Assistance, U.S. Department of Labor
200 Constitution Ave. NW, DC, 20210
Phone 866-444-3272
You may call them to obtain publications about your rights and responsibilities under ERISA.

SECTION 14. VALUE-ADDED SERVICES & DISCOUNTS

Membership with Moda Health includes other advantages as well. We give you access to additional services, programs and tools to support your physical, mental and emotional health. When you use these programs, you may receive savings on an item or service that is covered by the Plan. These resources are not part of the Plan, and they are not insurance. Access these extras through your Member Dashboard.

Your enrollment in the Plan automatically gives you access to these programs. Your access to these services ends when your coverage under the Plan ends. We may also discontinue these services for everyone. If we do this, we will notify the Group 30 days in advance.

We may have drawings for gift cards to encourage you to set up accounts from our Moda Health website or other program sites. When an offer is available, we will let you know the details and how to participate.

Employee Assistance Program
Through the Employee Assistance Program (EAP) with Canopy, you get 4 counseling sessions per incident for things like:

a. Work issues, including career development or conflicts at work
b. Family relationships, including marital problems
c. Depression, anxiety or grief
d. Stress management
e. Alcohol or drug abuse

You are also eligible for:

a. Financial coaching
b. Legal/Mediation help: one 30-minute consultation (up to 3 in a year) and a 25% discount for follow-up services
c. Identity theft services: one 60-minute consultation with a Fraud Resolution Specialist

These services are free. Call 800-826-9231 to start the program.

Travel Assistance Services
When you are traveling for 90 days or less, and your trip takes you outside of the United States or more than 100 miles from your permanent home, Assist America provides travel assistance. Services include:

a. Medical consultation, evaluation and referral
b. Foreign hospital admission assistance
c. Emergency medical evacuation
d. Arrangements to be transported home or to a rehabilitation facility after you are discharged from the hospital
e. Care of minor children left unattended as a result of medical emergency

Download the Assist America mobile app for one-touch calling when you need help. You can also call Assist America at 800-872-1414, or email at medservices@assistamerica.com.

Diabetes Management Program
Through Teledoc Health's diabetes management program, you can get these things for free:

a. A connected glucose meter, strips, lancing device and lancets
b. Monitoring blood glucose readings
c. Coaching on nutrition and lifestyle questions

Contact Teledoc Health at 800-835-2362 to access the program.

Chronic Kidney Disease Management
Comprehensive support for chronic kidney disease and end-stage renal disease (ESRD) through Strive Health is available if you qualify. It is free and includes:

a. Access to direct care centers offering disease management and education
b. Phone and virtual visits, including 24 hour access for questions and emergencies
c. Support through wellness checks, disease management, and education
d. Transition planning and support, facility navigation and renal replacement therapy

If you have chronic kidney disease, you will be invited to participate in the program. The invitation will tell you how to get started, or you can call Strive Health at 503-664-9111.

Prescription Savings Programs

a. Incentive to refill on time:

If you have diabetes or cardiovascular conditions, the Sempre Health prescription savings program encourages you to refill your prescriptions on time. When you refill your qualifying diabetes and cardiovascular medications as prescribed, you can receive cost sharing discounts through Sempre Health. You will get alerts when it is time to refill your prescriptions. Your discounts may increase as you continue to refill your prescriptions on time.

If you are prescribed qualifying medications, you will be invited to participate. The invitation will tell you how to get started. It is free to join. Contact Sempre Health at 855-910-0555 if you have questions.

b. Savings on 6-month supply:

Through the 6 for 6 program by Navitus and Costco, you can get a 6-month supply of certain medications for $6 at Costco warehouse retail pharmacies. You do not need a Costco membership to use this program. The list of medications in the program is at: info.navitus.com/6for6. Does not apply to mail order. Call 888-361-1610 if you have questions.

Active&Fit Direct
Through the Active&Fit Direct program, you can get discounted gym memberships at locations nationwide. You can change your membership to a different gym at any time. There are thousands of digital workout videos and digital resources and classes available online.

To participate you pay a one-time enrollment fee of $84 that is good as long as you continue your enrollment. Your enrollent fee includes your first two months. The monthly membership fee is $28.

Find out which fitness centers participate with Active&Fit Direct by going to their website through your Member Dashboard. You may call Customer Service at 844-646-2746 for help.

Active&Fit Direct is through American Specialty Health Incorporated (ASH). ASH has the right to change any part of the program, including the enrollment or monthly membership fees. ASH will notify you at least 30 days before changing fees. Fitness centers, amenities and classes vary by location, and taxes may apply. Any non-standard services that typically require an additional fee are not included.

Wellness Products and Services

ChooseHealthy gives you access to the following health and wellness services at no cost:

a. Discounts on popular health and fitness brands
b. Savings of up to 25% on services from specialty health practitioners including acupuncture, chiropractic and therapeutic massage
c. Access to no-cost online health classes

You may call Customer Service at 877-335-2746 for help. The ChooseHeaalthy program is provided by ChooseHealthy, Inc., a subsidiary of American Specialty Health Incorporated (ASH).

Discounts for Rose Quarter Events

Occasionally, we may offer discounts or the opportunity to buy tickets in advance to Rose Quarter events. We will tell your plan's group administrator when discounts or advance tickets are available. They will share this opportunity with subscribers. Tickets are available on a first come, first served basis. RoseQuarter.com administers discounts or advance tickets, and that is where you buy tickets or redeem your discount.

Nondiscrimination notice

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

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

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

If you need any of the above, call:

888-217-2363 (TDD/TTY 711)

If you think we did not offer these services or discriminated, you can file a written complaint. Please mail or fax it to:

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

Scott White coordinates our nondiscrimination work:

Scott White,
Compliance Officer
601 SW Second Ave.
Portland, OR 97204
855-232-9111
compliance@modahealth.com

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

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

U.S. Department of Health
and Human Services
200 Independence Ave. SW, Room 509F
HHH Building, Washington, DC 20201

800-368-1019, 800-537-7697 (TDD)

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

modahealth.com

moda HEALTH DELTA DENTAL

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

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

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

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

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

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

توجہ دیں: اگر آپ اردو (URDU) بولتے ہیں تو لسانی اعانت آپ کے لیے بلا معاوضہ دستیاب ہے۔ پر کال کریں 1-877-605-3229 (TTY: 711)

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

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

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

ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपको भाषाई सहायता बिना कोई पैसा दिए उपलब्ध है। 1-877-605-3229 पर कॉल करें (TTY: 711)

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

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

ModaORSGbk 1-1-2025

અગત્યનું: જો તમે (ભાષાંતર કરેલ ભાષા અહીં દર્શાવો) બોલો છો તો તે ભાષામાં તમારે માટે વિના મૂલ્યે સહાય ઉપલબ્ધ છે. 1-877-605-3229 (TTY: 711) પર કૉલ કરો

ໂປດຊາບ: ຖ້າທ່ານເວົ້າພາສາລາວ, ການຊ່ວຍເຫຼືອດ້ານພາສາແມ່ນມີໃຫ້ທ່ານໂດຍບໍ່ເສັຍຄ່າ. ໂທ 1-877-605-3229 (TTY: 711)

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

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

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

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

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

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

FA'AUTAGIA: Afai e te tautala i le gagana Samoa, o loo avanoa fesoasoani tau gagana mo oe e le totogia. Vala'au i le 1-877-605-3229 (TTY: 711)

IPANGAG: Nu agsasaoka iti Ilocano, sidadaan ti tulong iti lengguahe para kenka nga awan bayadna. Umawag iti 1-877-605-3229 (TTY: 711)

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

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