Important Group Health Plan Disclosure Information

Various state and federal agencies regulate health plan carriers. This document contains or references other sources of information that we are required to provide to you upon your enrollment into a health plan. If you have any questions about this information, please call our Medical Customer Service Department at 855-522-9807. For pharmacy questions, please call our Pharmacy Customer Service Department at 866-940-0360. You can also access tools and resources on your personalized member website, myModa, at www.modahealth.com/washington. myModa is available 24 hours a day, seven days a week allowing members to access plan information whenever it's convenient.

Accreditation status

We are committed to providing high-quality healthcare services for all our members. The National Committee for Quality Assurance (**NCQA**) awarded its accreditation status of Commendable to the Moda Health Washington Commercial Preferred Provider Organization (PPO) lines of business. NCQA is an independent, not-for-profit organization dedicated to assessing and reporting on the quality of healthcare plans and organizations. Its mission is to improve healthcare quality and to help consumers, employers and others make more informed healthcare choices.

Annual accounting of payments made under a health plan

We can provide you an annual accounting of all payments made by the health plan which counted towards any payment limitations, visit limitations or other overall limitations on your coverage plan.

Appeals

Group health plans have a two level appeal process. You have 180 days from the date of an adverse benefit determination to submit an initial written appeal. If an appeal is not submitted within required timeframes, rights to the appeals process will be lost.

You may review the claim file and present evidence and testimony as part of the appeal process, and may appoint a representative to act on your behalf. We will conduct an investigation by persons who were not involved in the initial determination.

An appeal related to an urgent care claim will be entitled to expedited review upon request.

Expedited reviews will be completed no later than 72 hours in total for the first and second level appeals combined after our receipt of the appeal, unless you fail to provide sufficient information for us to make a decision. In this case, we will notify you within 24 hours of receipt of the appeal of the specific information necessary to make a decision. You must provide the specified information as soon as possible.

Investigation of an appeal will be completed and a notice sent within 14 days and no more than 20 business days for post-service denials due to experimental or investigational basis.

Investigation of other post-service appeals may be extended with a notice. Investigation will be completed and a notice sent within 30 days. Expedited review and concurrent expedited review will be completed within 24 hours when possible but in no case longer than 72 hours of the receipt of the request.

For group plans, we will send a written notice of the decision, the basis for the decision, and if applicable, information on the right to a second level appeal. Members can request expedited internal or external review or concurrent expedited review for urgent care claims.

In the last required appeal level, if new or additional evidence or rationale is used by us in connection with the claim, it will be provided, in advance and free of charge, before any final internal adverse benefit determination. You may respond to this information or request more time to review before our determination is finalized. Moda Health will send a written notice of the decision, the basis for the decision, and if applicable, information on the right to external review.

Benefits and exclusions

Upon request, we will provide you with a summary of benefits and coverage (SBC) and an uniform glossary.

Consumer involvement in benefit decisions

We welcome comments and questions about our efforts to monitor and improve healthcare quality. Please contact our Medical Customer Service Department if you have any questions.

Documents referenced in member handbook or policy

You can request to review documents referenced in your member handbook or policy, including your health plan's formularies on prescription drugs, durable medical equipment, and prosthetic appliances; documents detailing patient rights and responsibilities; and documents describing grievance and appeal procedures.

External review

External review by an independent review organization is available for disputes related to an adverse benefit determination based on medical necessity, appropriateness, health care setting, level of care, or that the requested service or supply is not efficacious or otherwise unjustified under evidence-based medical criteria; or when we fail to meet the internal timeline for review or the federal requirements for providing related information and notices.

The request for external review must be in writing no more than 180 days after receipt of the final internal adverse benefit determination. For an urgent care claim or when the claim concerns a condition for which the member received emergency services and is still hospitalized, a request for external review may be expedited or simultaneous with a request for internal appeal review.

We will provide the information to the independent review organization within three business days and notify you of the name of the independent review organization and the right to submit additional information within one day of selecting the independent review organization. You may submit additional information in writing to the independent review organization within five business days from receipt of the notice.

The independent review organization will make a final determination and notify the member within 15 calendar days for non-expedited reviews (within 20 calendar days with incomplete information and within 25 calendar days for exceptional circumstances together with incomplete information) or 72 hours for expedited review.

Grievance

Grievance means a written complaint submitted by you or on your behalf regarding issues other payment for healthcare services. Grievance includes dissatisfaction with healthcare services, delays in obtaining healthcare services, conflicts with providers or Moda Health's staff, and dissatisfaction with Moda Health's practices or actions unrelated to healthcare services.

You may submit a grievance to us or contact our Medical or Pharmacy Customer Service Department for assistance. We will make a determination and notify you of the determination.

Maternity coverage

For group plans, we cover pregnancy care, childbirth and related conditions, prenatal testing for congenital disorders as well as follow-up care when rendered by a professional provider who is a physician, a certified nurse midwife, a licensed midwife, a licensed physician assistant or an advanced registered nurse practitioner. Facility charges for maternity care are covered when rendered at a covered facility, including a birthing center. For home births, we cover medically necessary supplies and fees billed by a professional provider. This maternity care benefit includes voluntary abortions.

Medical necessity

Medical necessity means those services and supplies that are required for diagnosis or treatment of illness or injury and are:

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

Newborns' and Mothers' Health Protection Act

Under federal law, group health plans and health carriers offering group health coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or

less than 96 hours following a cesarean section. However, the mother's or newborn's attending professional provider, after consulting with the mother, may discharge the mother or her newborn earlier than 48 hours following a vaginal delivery or 96 hours following a cesarean section. Providers are not required to obtain authorization for a length of stay up to 48 hours (or 96 hours after a cesarean section) following childbirth.

Plans and carriers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

Payment arrangements with providers

Expenses allowed by Moda Health are based upon the contracted fees for services rendered by in-network providers and the maximum plan allowance for services of out-of-network providers.

For out-of-network providers other than a facility, the maximum plan allowance is the lesser of:

a) The amount that is negotiated with the provider;
b) The 75th percentile of fees commonly charged for a given procedure in a given area, based on a national database;
c) 75% of the billed charge if a dollar value is not available in the national database;
d) A comparable code to the one billed as determined by Moda Health's medical consultant when a dollar value is not available in the database.

For out-of-network facilities, including, but not limited to, hospitals, ambulatory surgical centers, home health providers, skilled nursing facilities, residential mental health treatment programs, residential chemical dependency treatment programs, hospice, or long-term care facilities, the maximum plan allowance is the lesser of:

a) The amount that is negotiated with the provider;
b) 125% of the Medicare allowable amount based on data collected from the Centers for Medicare and Medicaid Services (CMS), or the billed charge. Medicare allowable amount is the fixed amount Medicare sets for a covered service; or
c) The billed charge.

For emergency services at out-of-network facilities, the maximum plan allowance is the greatest of:

a) The median in-network rate;
b) The maximum amount as calculated according to this definition for out-of-network facility; and
c) The Medicare allowable amount.

MPA for medical devices, including implanted medical devices, and for durable medical equipment is the contracted amount, or the lesser of 125% of the Medicare allowable amount, or the acquisition cost of the device plus 10% if there is no contracted amount.

For group plans with pediatric dental coverage, the benefit is based on a fixed payment schedule. The balance between the fixed payment amounts and the billed charges is the member's responsibility. If the fixed payment amounts exceed the billed charges, the Plan pays up to the billed charges.

MPA for end-stage renal disease (ESRD) facilities during the first 3 months of treatment is the contracted amount for in-network facilities and is based on a supplemental facility fee arrangement for out-of-network facilities. After the first 3 months, MPA is 125% of the Medicare allowable amount for both in-network and out-of-network ESRD facilities.

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

To receive maximum benefits you should seek service from in-network providers. You will have higher out-of-pocket costs if you utilize providers who are not in the network. An out-of-network provider has the right to bill the difference between the maximum plan allowance and the actual charge. This difference will be your responsibility in addition to any deductible, copayments, coinsurance, cost containment penalties and disallowed charges.

Except for copayments, coinsurance, deductibles, and policy benefit limitations, in-network providers agree to look solely to Moda Health, if it is the paying health carrier, for compensation of covered services provided to members. Nothing in this paragraph shall prohibit you and a provider from entering into an agreement for payment by you for medical services that are not covered by us.

Pharmacy benefits

The following information applies only to health plans that have pharmacy benefits. This information is detailed in your Member Handbook or policy.

Definitions of pharmacy-related terms:

Brand name drug: A brand name drug is sold under a trademark and protected name.

Brand Substitution: Both generic and brand drugs are covered. If a member requests, or the treating professional provider prescribes, a brand drug when a generic equivalent is available, the member will be responsible for the brand cost sharing plus the difference in cost between the generic and brand drug, not to exceed the total cost of the medication. In instances when a professional provider restricts brand substitution due to refractory conditions or therapeutic inefficacy, the member will be responsible for the brand coinsurance.

Compounded prescription drugs: Compounded medications contain at least one covered drug as the main ingredient and are covered under the health plan.

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

Formulary: A formulary is a listing of all prescription medications and their coverage under the prescription drug benefit. A formulary look up tool is available on the Moda Health website in myModa under the pharmacy tab or by contacting our Pharmacy Customer Service Department.

Legend medications: Those medications that include the notice "Caution - Federal law prohibits dispensing without prescription".

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

Specialty drugs: Certain prescription drugs are defined as specialty products. Specialty treatments often require special handling techniques, careful administration and a unique ordering process. Specialty drugs must be prior authorized and medically necessary.

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

Your right to safe and effective pharmacy services

State and federal laws establish standards to assure safe and effective pharmacy services, and to guarantee your right to know what drugs are covered under your health plan and what coverage limitations are in your contract. If you would like more information about the drug coverage policies under your plan, or if you have a question or a concern about your pharmacy benefit, please contact our Pharmacy Customer Service Department. If you would like to know more about your rights under the law, or if you think anything you received from your health plan may not conform to the terms of your contract, you may contact the Washington State Office of the Insurance Commissioner at 800-562-6900. If you have a concern about the pharmacists or pharmacies serving you, please call the Washington State Department of Health at 800-525-0127.

Additional information beyond your covered benefits

In addition to a detailed list of covered benefits, you can get information about prescription drug coverage that may be included in your plan. Your health plan has a specific list of drugs, called a formulary, for those plans that include prescription drug coverage in the plan benefits. There is also a process that allows your provider to prescribe a drug that is not on the formulary list, or is only covered for certain conditions. Your doctor can request that a drug be covered under the medical plan due to medical necessity for a patient's specific medical condition. RCW 48-43-510 (1g)

Does this plan limit or exclude certain drugs my healthcare provider may prescribe, or encourage substitutions for some drugs?

Your health plan may impose administrative plan edits and provisions that ensure appropriate access to medications based on patient demographics, high dollar thresholds, quantity limits and in accordance with the parameters of the prescription as written by your professional provider.

a) Retail prescriptions with a net cost over $1,000 for a 30-day supply require authorization.
b) Mail-order and specialty prescriptions with a net cost over $3,000 require authorization.
c) New FDA approved drugs are subject to review and may be subject to additional coverage parameters, requirements, or limits established by the Plan.
d) Compounded medications with a net cost over $150 for a 30-day supply require a prior authorization.
e) Select specialty medications may be limited to a 15-day supply for medications that have been determined to have a high discontinuation rate or short duration of use.
f) Claims for drugs purchased outside of the United States and its territories will only be covered in emergency and urgent care situations, except when reasonable accommodation is prior authorized.
g) Early refill of medications for travel outside of the United States is limited to once every 6 months unless prior authorized.
h) Specialty medications with dosing intervals beyond 30 days will be assessed an increased copayment consistent with the day supply.
i) Off-label use. A medication prescribed for or used for non-FDA approved indications may be subject to have the indication confirmed by research studies, reference, compendium, or the federal government.

Both generic and brand name medications are covered. If you request a brand name drug or the treating professional provider prescribes a brand name drug when a generic equivalent is available, you may be responsible for the brand copayment/coinsurance plus the difference in cost between the generic and the brand name drug. In instances where a professional provider restricts brand substitution due to refractory conditions or therapeutic inefficacy, you will be responsible for the brand copayment/coinsurance.

The preferred drug list is not meant to replace a professional provider's judgment for prescribing decisions. It is designed to offer cost effective choices that will save you money on prescription drugs. Your health plan does not take responsibility for any drug decisions made by the prescriber or dispensing pharmacist.

Certain prescription drugs and/or quantities of prescription drugs may require prior authorization. Prior authorization programs are not intended to create barriers or limit access to medications. Medications requiring prior authorization are evaluated with respect to evidence based criteria that align with medical literature, best practice guidelines and guidance from the FDA. Requiring prior authorization is intended to support cost effectiveness, promote proper use of medications and to ensure member safety.

Prior authorizations may be required on medications for a variety of reasons, including the examples listed below:

a) Utilization control edits. Medications may have limited use, be prone to overuse or prescribed in quantities outside the recommended FDA indications.
b) Cost effectiveness. There may be therapeutically equivalent medications that are less expensive.
c) Prescribing guidelines. Medications may require diagnostic testing to ensure safety and efficacy of the treatment.
d) Benefit coverage. Medication may be prescribed for conditions that are excluded under the Plan.

A step therapy provision may apply for certain therapeutic classes. A step therapy provision will require you to try and fail selected medications before proceeding to higher cost alternatives.

Brand drugs are available as shown in the schedule of benefits of the policy, once members have tried and failed first line therapies.

Over the counter (OTC) products, vitamins, drugs for cosmetic purposes, immunizations for travel purposes, and hair growth products are typically excluded under all plans. Exclusion of other drug categories such as infertility, weight loss, and sexual dysfunction will depend upon your health plan's specific coverage of these treatments. Coverage for medications can be verified using the formulary look-up and price quote tool in myModa or by contacting our Pharmacy Customer Service Department.

When can my plan change the approved drug list (formulary)? If a change occurs, will I have to pay more to use a drug I had been using?

Your health plan will conduct frequent pharmaceutical class reviews and corresponding tier level reviews which support periodic updates to the preferred drug list. Your health plan will initiate pharmaceutical class reviews throughout the calendar year.

Selection of pharmaceutical class reviews are dependent on a number of variables, including:

a) New generics entering the market requiring an update and review of the current formulary.
b) New brand name medications entering the market which offer a potential advantage to existing treatment options.
c) Changing or updating PA criteria for specific drugs within a pharmaceutical class.

Modifications to the preferred drug list reflecting new drugs or changes in treatment patterns will be made throughout the year. You are notified by letter if the change will have a negative impact (higher copayment, utilization management edits, etc.). A current preferred drug list is available on the Moda Health website or by contacting our Pharmacy Customer Service Department.

When a generic becomes available for a brand name medication, the brand name drug will be moved to the brand tier. If you receive a brand name drug when a generic is available, you may pay the difference between the brand name and generic drug in addition to your copayment.

What should I do if I want a change from limitations, exclusions, substitutions, or cost increases for drugs specified in this plan?

If the treating professional provider would like to discuss a specific limitation, exclusion, substitution or cost increase with a physician reviewer, he or she may contact our Pharmacy Customer Service Department.

If you do not agree with a limitation, exclusion, substitution or cost increase, you have the right to file an appeal by providing a written request. You may also present additional evidence and testimony to support the request.

If you are not satisfied with the outcome of the appeal process, you may request that the claim be reviewed by an independent review organization at no cost to you.

Additionally, you may contact Washington Consumer Assistance Program at 800-562-6900 for questions about your appeal rights or for assistance.

How much do I have to pay to get a prescription filled?

The amount you will need to pay for your prescriptions depends on the type of prescription drug benefit you or your employer group purchased and the drug prescribed. Applicable copayments or coinsurances are per prescription and are typically for a 30 day supply through an in-network retail pharmacy and a 90 day supply through the contracted mail order pharmacy.

Copayments or coinsurance for specialty medications are assessed per 30 day prescription and are typically limited to a 30 day supply; however some specialty medications may be limited to a 14 or 15 day supply with a prorated copayment/coinsurance per dispensed medication supply. Some medications with a dosing regimen extending beyond a 30 day supply per prescription fill will be assessed a copayment for each 30 day supply not to exceed three copayments per prescription fill.

If you receive a brand name drug when a generic is available, you may pay the difference between the brand name and generic drug in addition to your copayment.

Do I have to use certain pharmacies to pay the least out of my own pocket under this health plan?

To ensure the highest level of benefits you should select an in-network network pharmacy. You can look up in-network pharmacies through our pharmacy locator tool online at www.modahealth.com/washington or by calling our Pharmacy Customer Service Department.

Your member identification card (ID) will provide the in-network pharmacy with the information necessary to process your claim and allow you to access your prescription drug benefits at the point of service. Please remember to present your member ID card to ensure your pharmacy has the most current benefit detail loaded in its system.

You also have the option of obtaining prescriptions for covered drugs and medicines through an exclusive mail-order pharmacy. Prescriptions purchased through the mail-order drug program are subject to the generic substitution policy. Mail-order pharmacy forms can be obtained from your employer, online or by contacting our Pharmacy Customer Service Department.

Certain prescription drugs or medicines, including most self-injectables as well as other medications defined as specialty products must be purchased through an exclusive specialty pharmacy provider to be a covered benefit. If you do not purchase these drugs at the in-network specialty pharmacy provider, the drug expense will not be covered.

At times, you may be required to submit a claim form and applicable receipts for reimbursement. For example, you fill a prescription at an out-of-network pharmacy that does not access our claims payment system will need to submit a request for reimbursement. Claims are subject to the administrative and benefit plan provisions, including but not limited to prior authorization requirements, step therapy and quantity level and day supply limitations.

How many days supply of most medications can I get without paying another copay or other repeating charge?

Applicable copayments or coinsurances are per prescription and are typically for a 30 day supply through an in-network retail pharmacy and 90 day supply through the contracted mail order pharmacy. Copayments or coinsurance for specialty medications are assessed per 30 day prescription and are typically limited to a 30 day supply; however some specialty medications may be limited to a 14 or 15 day supply with a prorated copayment/coinsurance per dispensed medication supply.

Some medications with a dosing regimen extending beyond a 30 day supply per prescription fill will be assessed a copayment for each 30 day supply not to exceed three copayments per prescription fill.

What other pharmacy services does my health plan cover?

Select vaccines and immunizations administered at a network pharmacy are covered through the prescription drug benefit. Benefits will be based on policy provisions and covered immunizations will be limited to those recommended by the Advisory Committee on Immunization Practices of the Center for Disease Control and Prevention. Specific vaccines, including vaccinations used for travel purposes, may not be covered.

Preferred Provider Organization (PPO) plan availability

You may see professional providers or go to facilities outside the health plan network for a lower level of coverage than in-network benefits. These types of plans offer more flexibility than coordinated care plans that provide benefits only when using network providers. If you use the out-of-network benefits you will usually pay more cost sharing and/or have more limitations on coverage.

Premium and member cost sharing

For group plans, information is available from your employer about any premium cost share that your employer requires for eligibility in the group medical plan. Information about member cost sharing is summarized in your plan's schedule of benefits document. This information is detailed in your plan's Member Handbook.

Prior authorization

The Plan requires prior authorization for many procedures and supplies. Members can access a complete list of procedures and supplies that require prior authorization by visiting our website or contacting our Medical Customer Service Department.

Prior authorization involves the following steps:

a) When a professional provider suggests admission to the hospital or a residential program, or a non-emergency surgery, the member should ask that he or she contact Moda Health for prior authorization.
b) The professional provider or his or her office staff either calls Moda Health or submits a prior authorization form.
c) Moda Health will either approve the admission, ask for additional information and/or request that the member get a second opinion. Moda Health may also specify that the member receive care on an outpatient basis only.
d) If admission is approved, Moda Health will authorize an appropriate length of stay.
e) The hospital, professional provider and member are notified of the outcome of the authorization process by letter.

Privacy statement

The confidentiality of your protected health information is of extreme importance to Moda Health. Protected health information includes, but is not limited to enrollment, claims, and medical and dental information. We use such information internally for claims payment, referrals and authorization of services, and business operations such as case management and quality management programs. A copy of our Notice of Privacy Practices is on page 13. We do not sell this information. In summary, 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 member information in order to perform their job functions are allowed to do so.
c) Disclosure outside the company 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.

Provider search

Members may choose an in-network provider by using “Find Care” on our website or by contacting Moda Health’s Medical Customer Service Department for assistance. Member ID cards will identify the applicable networks.

Quality program

The Moda Health Board of Directors oversees all Moda Health quality programs. It delegates the operation to the Medical Quality Improvement Committee (MQIC) whose members, including senior executives and the company’s chief medical officer, represent key service areas

of the health plan. Using industry-standard tools, the committee monitors, measures and evaluates the quality of services provided to members throughout the year.

A description of our quality programs and a report on our progress in meeting our goals is available at www.modahealth.com.

Women's healthcare practitioners

You have the right to direct access to licensed women's healthcare practitioners for covered women's healthcare services.

Women's Health and Cancer Rights Act of 1998.

As required by the Women's Health and Cancer Rights Act of 1998, we cover reconstructive surgery following a mastectomy for:

a) All stages of reconstruction of the breast on which the mastectomy has been performed, including but not limited to nipple reconstruction, skin grafts and stippling of the nipple and areola;
b) All stages of surgery and reconstruction of the other breast to produce a symmetrical appearance;
c) Prostheses;
d) Mastectomy bras;
e) Treatment of physical complications of the mastectomy, including lymphedemas; and
f) Inpatient care related to the mastectomy and post-mastectomy services.

This coverage will be provided in consultation with your attending physician and will be subject to the same terms and conditions, including the annual deductible and copayment or coinsurance provisions otherwise applicable under the plan.

Notice of Privacy Practices

We Care About Your Privacy

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information and to notify affected individuals following a breach of unsecured protected health information. This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

At Moda Health, we respect the privacy of your protected health information and will maintain its confidentiality in a responsible and professional manner. Protected health information includes any information regarding your healthcare that can identify you as the recipient of the healthcare services. We are required by law to provide you with this notice and abide by its terms. This notice explains how we gather and use information about you and when we can share information with others. It also describes your rights as our valued customer and how you can exercise these rights.

How we collect and protect information

We collect information from enrollment or application forms. Examples of information gathered are: Member name, address and Social Security Number, general health status information, employment and other information relevant to coverage. We also collect information from healthcare coverage transactions with Moda Health and our affiliates.

This includes information such as claims, service authorization requests, deductible and copayments. While most information we collect is in writing, we may also gather information in person, by telephone or electronically.

We ensure the security of your information through physical, technical and procedural safeguards. All information collected is treated in a confidential and secure manner whether you are a prospective, current or former customer.

How we use or share information

We use protected health information and may share it with others to assist in your treatment, payment for your treatment, and our business operations.

- We will use the information to pay your healthcare bills that have been submitted to us by dentists, doctors, hospitals and others.
- We may share your information with healthcare professionals to help them provide medical and dental care to you. For example, we may send medical information about you to a specialist as part of a referral.
- We may use or share your information with others to help manage your healthcare. For example, we may talk to your doctor to suggest a disease management or wellness program that could help improve your health.

Providing healthcare information where it's needed

We may use information about you for the following reasons:

- To give you information about alternative medical treatments and programs, or about health-related products and services you may be interested in. For example, we sometimes send out newsletters to let you know about "healthy living" alternatives such as smoking cessation or weight loss programs.
- For underwriting or other activities relating to the issuance of a contract for health coverage. Please note that we are prohibited from using or disclosing genetic information for underwriting purposes.

We may share your information for the following reasons:

- With a family member or friend to the extent necessary to help with your healthcare or with payment for your healthcare when you are unable to provide authorization due to, for example, a medical emergency.
- With authorized private or public entities to assist in disaster relief efforts.
- With other individuals or companies who perform business functions on our behalf. For example, we may share your information with a company that does data entry on our behalf.
- With the plan sponsor, agent or consultant of the employee benefit plan through which you receive health benefits, to permit the sponsor to perform plan administration functions.

Protecting your personal healthcare information

Additional types of disclosures:

We will not use or disclose your protected health information unless we are allowed or required by law to do so. We may make additional types of disclosures to:

- State and federal agencies who regulate us. (For example, the U.S. Department of Health and Human Services and the State Insurance Department.)
  Authorized public health agencies. For instance, we may report concerns to the Food and Drug Administration regarding prescription drug and medical device problems.
  Appropriate authorities, if we believe you are a victim of child abuse or neglect, domestic violence or other crimes.
  The appropriate agencies, if we believe there is a serious health or safety threat to you or others.
- Health oversight agencies for activities authorized by law including audits, criminal investigations, licensure or disciplinary actions.
- Law enforcement agencies for identification and location of a suspect, fugitive, material witness, crime victim or missing person.
- A court or administrative agency in response to a search warrant, subpoena or other lawful process.
- Coroners, medical examiners and organ procurement entities and for research in limited cases.

- Military authorities and authorized federal officials for intelligence, counterintelligence, and other national security activities.
- The extent necessary to comply with laws relating to worker's compensation or other similar programs.
- A public or private entity authorized by law to assist in disaster relief efforts.

Where your authorization is required

Your authorization is required for uses and disclosures other than those allowed or required by law. These uses and disclosures for which an authorization is required include but are not limited to:

- Most uses and disclosures of psychotherapy notes.
- Uses and disclosures of your protected health information for marketing purposes.
- Disclosures that would constitute the sale of your protected health information.

Know your rights

Your rights include the right to:

- Request that we not use or disclose your protected health information for treatment, payment or healthcare operations, or to persons involved in your care except when specifically authorized by you, when required by law or in an emergency.
- Request that your protected health information be communicated to you in a confidential manner, such as sending mail to an address other than your home. The request must be made in writing. We will accommodate reasonable requests.
- In most cases, you have the right to inspect and obtain a copy of protected health information records that we use to make decisions about your care. Your request must be made in writing. We may charge a reasonable fee for copying and postage.
  Request that we amend the records, if you believe that the protected health information in your record is incorrect or if important information is missing. Your request must be in writing and include the basis for your request. We may deny your request if the information was not created by us, if it is not maintained by us, or if we determine that the record is accurate.
- Receive notifications of a breach of your unsecured protected health information.
- Receive an accounting of certain disclosures of your information made by us during the six years prior to your request. The accounting will not include disclosures that were made:
  - For treatment, payment and healthcare operations purposes
  - To you
  - Incidental to a use or disclosure otherwise permitted
  - Pursuant to your authorization
  - To persons involved in your care
  - For national security or intelligence purposes
  - To correctional institutions or law enforcement agencies

- As part of a limited data set for research, public health or healthcare operations purposes; and
- Prior to April 14, 2003

We will provide one accounting upon request every 12 months at no charge. We may charge a fee for an additional accounting within 12 months. We will inform you in advance of the fee and allow you to withdraw or modify your request.

Exercising your rights

> You have a right to receive a paper copy of this notice upon request at any time. Visit www.modahealth.com to access this notice.
> If you have any questions about this notice or about how we use or disclose information, please contact the Moda Health Privacy Office at 503-243-4492 or 800-852-5195, ext. 4492 Monday through Friday, from 8:30 a.m. to 4:30 p.m.
> If you believe your privacy rights have been violated, you may send a complaint to:

Moda Health
Attn: Privacy Office
601 S.W. Second Ave.
Portland, OR 97204

> You may also file a written complaint with the Department of Health and Human Services (DHHS), Office of Civil Rights. Visit www.hhs.gov/orc to find the contact information. You may also contact our office for more information.
> We will not take any action against you for filing a complaint.

Changes to our notice

This notice is effective on August 1, 2013. We reserve the right to change the terms of this notice and to make the new notice effective for all protected health information we maintain. If revised, we will notify you that a change has been made by mailing you a new Notice of Privacy Practices. The new notice will also be available online at www.modahealth.com.