OREGON EDUCATORS
OEBB
BENEFIT BOARD

Group Medical Plan
OEBB

Medical Home Plan
Plan E / Synergy Network
Effective Date: October 1, 2015

moda

modahealth.com

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SECTION 1 WELCOME

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

Members also have access to certain value-added services through Moda Health in addition to the benefits outlined in this handbook, including a weight management program and the Moda Health associated smoking cessation program. Visit myModa or contact Moda Health Customer Service for more information about these additional value-added services.

During a first appointment, the member should tell their medical provider that they have medical benefits through Moda Health. The member will need to provide their subscriber identification number and Moda Health Group number. These numbers are located on the I.D. card.

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

Moda Health reserves the right to monitor telephone conversations and e-mail communications between its employees and its customers for legitimate business purposes as determined by Moda Health. The monitoring is to ensure the quality and accuracy of the service provided by employees of Moda Health to their customers.

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

1.1 MEMBER RESOURCES

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

Medical Customer Service Department
Portland 503-265-2909; Toll-free 866-923-0409
En Español 503-265-2961; Llamado gratis 888-786-7461

Behavioral Health
Portland 503-382-5323; Toll-free 1-877-796-3223

Pharmacy Customer Service Department
Portland 503-265-2911; Toll-free 866-923-0411

Prior Authorization
Portland 503-243-4496; Toll-Free 800-258-2037

Telecommunications Relay Service for the hearing impaired
711

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

SECTION 2 SUMMARY OF BENEFITS – A QUICK REFERENCE

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

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

2.1 NETWORK INFORMATION

In-network benefits apply to services delivered by medical home providers or providers with a referral. Out-of-network benefits apply to services delivered by non-medical home providers or providers without a referral (see section 6 for more information on medical homes). By using a medical home provider, members will receive quality healthcare and will have a higher level of benefits. Members may find a medical home provider by using "Find Care" on myModa or by contacting Customer Service for assistance. Member ID cards will identify the applicable network(s).

2.1.1 Primary Network; Primary Service Area

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

Networks

The Synergy Network is available to residents or working in the following counties: Benton, Clackamas, Clark, Clatsop, Columbia, Hood River, Jackson, Josephine, Klamath, Lane, Lincoln, Linn, Marion, Multnomah, Polk, Tillamook, Wasco, Washington and Yamhill. A list of eligible zip codes is available at modahealth.com/oebb.

If a member sees an Connexus provider who is not part of the Synergy network, benefits will be at the out-of-network level. Members can see providers at nearby hospitals and clinics or at certain Portland Metro hospitals for specialized needs.

2.1.2 Coverage Outside The Service Area For Children

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

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

When an enrolled child moves outside the service area, members must update the address in the myOEBB system. The enrolled child will be eligible for out-of-area coverage the first day of the month following the date the address is update in myOEBB.

2.1.3 Travel Network

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

Travel Network
PHCS Healthy Directions

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

2.1.4 Care After Normal Office Hours

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

2.2 SCHEDULE OF BENEFITS

Note: Benefits are paid on a Plan Year beginning October 1st of each year and ending September 30th of the following year.

	In-Network Benefits	Out-Of-Network Benefits
Plan year deductible per member	**$1,000***	
Maximum plan year family aggregate deductible	**$3,000***	
Plan year out-of-pocket maximum per member	**$ 4,250**	**$ 8,500**
Plan year out-of-pocket maximum per family	**$12,700**	**$25,400**
Plan year Maximum Cost Sharing per member (includes out-of-pocket, additional cost tier and pharmacy)	**$ 6,600**	**no maximum**
Plan year Maximum Cost Sharing per family (includes out-of-pocket, additional cost tier and pharmacy)	**$13,200**	**no maximum**

*Deductible will be reduced by $100 per member (up to $300 per family) if Healthy Futures requirements are met (section 16.3).

Services	**Cost Sharing** (Deductible applies unless noted differently)		**Section in Handbook and Details**
	In-Network	**Out-Of-Network**	
Emergency Care			
Urgent Care Office Visit	$50 copayment per visit, deductible waived	$50 copayment per visit, deductible waived	Section 7.8.3 In-network out-of-pocket maximum applies to mental health and chemical dependency services
Emergency Room Facility	$100 copayment per visit, then 20%	$100 copayment per visit, then 20%	Section 7.4 Copayment waived if covered hospitalization immediately follows emergency room use. In-network out-of-pocket maximum applies to mental health and chemical dependency services.

Services	Cost Sharing (Deductible applies unless noted differently)		Section in Handbook and Details
	In-Network	Out-Of-Network	
Ambulance Transportation	20%	20%	Section 7.5 In-network out-of-pocket maximum applies.
Hospital Care and Residential Facility Care			
Inpatient Acute Care	20%	50%	Section 7.6.3
Inpatient Chemical Dependency Treatment	No cost sharing	50%	Section 7.6.3
Inpatient Rehabilitation	20%	50%	Section 7.6.4 30 days per plan year. May be eligible for up to 60 days for head or spinal cord injury.
Skilled Nursing Facility Care	20%	50%	Section 7.6.5 60 days per plan year.
Partial Hospital Treatment & Day Treatment Programs for Chemical Dependency	No cost sharing	50%	Section 7.6.6
Chemical Dependency Detoxification	No cost sharing	50%	Section 7.6.7
Residential Mental Health Treatment Programs	20%	50%	Section 7.6.6
Residential Chemical Dependency Treatment Program	No cost sharing	50%	Section 7.6.6
Ambulatory Services			
Outpatient Surgery and Invasive Diagnostic Procedures (Facility Charges)	20%	50%	Section 7.7.1 Requires authorization
Outpatient Rehabilitation	20%	50%	Section 7.7.2 30 sessions per plan year. May be eligible for up to 60 sessions for head or spinal cord injury. May require authorization.

Services	Cost Sharing (Deductible applies unless noted differently)		Section in Handbook and Details
	In-Network	Out-Of-Network	
Infusion Therapy			Section 7.7.3
Coram Home Infusion for chemotherapy	20%	N/A	
Coram Home Infusion for all other infusion services	No cost sharing	N/A	Requires authorization
Home Infusion all other providers	20%	50%	Requires authorization
Outpatient Infusion	20%	50%	Requires authorization
Diagnostic X-ray and Lab			Section 7.7.4
At Quest Labs	No cost sharing	N/A	
All other providers	20%	50%	
Therapeutic X-ray	20%	50%	Section 7.7.5
Kidney Dialysis	20%	50%	Section 7.7.5
Outpatient Chemical Dependency Services	No cost sharing	50%	Section 7.7.7
Professional Services			
Preventive Healthcare			
Services as required under the Affordable Care Act, including, but not limited to the following:	No cost sharing	50%	Section 7.8.1
Periodic Health Exams	No cost sharing	50%	Section 7.8.1 7 exams from age 1 to 4 One per plan year, age 5+
Immunizations	No cost sharing	50%	Section 7.8.1
Hearing Evaluation	No cost sharing	50%	Section 7.8.1
Routine Vision Screening	No cost sharing	50%	Section 7.8.1 Age 3 to 5
Women's Exam & Pap Test	No cost sharing	50%	Section 7.8.1 One per plan year
Routine Mammogram	No cost sharing	50%	Section 7.8.1 One per plan year, age 40+
Routine Colonoscopy	No cost sharing when performed on an outpatient basis	50%	Section 7.8.1

Services	Cost Sharing (Deductible applies unless noted differently)		Section in Handbook and Details
	In-Network	Out-Of-Network	
Routine Diagnostic X-ray & Lab	No cost sharing	50%	Section 7.8.1
Cardiovascular Screening	No cost sharing	50%	Section 7.8.1
Obesity Screening	No cost sharing	50%	One per plan year
Prostate Rectal Exam	No cost sharing	50%	Section 7.8.1 One per plan year, age 50+
Prostate Specific Antigen (PSA) Test	No cost sharing	50%	Section 7.8.1 One per plan year, age 50+
Moda Medical Home Wellness Visit	No cost sharing	N/A	Section 7.8.1 Age 21+
Moda Medical Home Incentive Care (for asthma, heart conditions, cholesterol, high blood pressure, and diabetes)	$15 copayment per visit, deductible waived	50%	Section 7.8.3 Member must see their selected medical home to receive the $15 copay.
Moda Medical Home Primary Care Office Visits	$30 copayment, deductible waived	50%	Section 7.8.3 Member must see their selected medical home to receive the $30 copay.
Primary Care Home and Office Visits (all other conditions)	50%	50%	Section 7.8.3
Specialist Office Visits	20%	50%	
Physician Hospital Visits	20%	50%	Section 7.8.3
Outpatient Diabetic Instruction	20%	50%	Section 7.8.4 Once, following diagnosis
Therapeutic Injections	20%	50%	Section 7.8.5
Surgery	20%	50%	Section 7.8.6
Special Dental Care	20%	50%	Section 7.8.12
Temporomandibular Joint Syndrome	20%	50%	Section 7.8.14
Outpatient Mental Health Services	$30 copayment per visit, deductible waived	50%	Section 7.8.15
Tobacco Cessation Treatment			Section 7.8.17 age 10+
Consultation			
Exclusive tobacco cessation -program	No cost sharing	N/A	

Services	Cost Sharing (Deductible applies unless noted differently)		Section in Handbook and Details
	In-Network	Out-Of-Network	
All other providers	No cost sharing	50%	
- Supplies (all providers)	No cost sharing	20%	
Hearing Aids and Related Services	10%	50%	Section 7.9.9 Every 48 months for members under age 26 $4,000 maximum every 48 months for members 26 and older
Chiropractic, Naturopathic & Acupuncture Care			Section 7.8.19 May require authorization.
Office visits	20%	50%	
All other services (e.g. spinal manipulation,)	20%	50%	$2,000 aggregate plan year maximum
Additional Cost Tier (for certain outpatient and hospital services)			
Imaging Procedures	$100 copayment per procedure, then 20%	$100 copayment per procedure, then 50%	Section 7.7.6 May require authorization. Copayment waived if billed with a primary diagnosis of cancer.
Sleep Studies	$100 copayment per study, then 20%	$100 copayment per study, then 50%	Requires authorization
Upper Endoscopy	$100 copayment per procedure, then 20%	$100 copayment per procedure, then 50%	Section 7.3
Spinal injections	$100 copayment per procedure, then 20%	$100 copayment per procedure, then 50%	Section 7.3
Viscosupplementation	$100 copayment per procedure, then 20%	$100 copayment per procedure, then 50%	Section 7.3
Tonsillectomy	$100 copayment per procedure, then 20%	$100 copayment per procedure, then 50%	Section 7.3 Applies to members under age 18 with chronic tonsillitis or sleep apnea

Services	Cost Sharing (Deductible applies unless noted differently)		Section in Handbook and Details
	In-Network	Out-Of-Network	
Lumbar Discography	$100 copayment per procedure, then 20%	$100 copayment per procedure, then 50%	Section 7.3
Arthroscopy (knee and shoulder)	$500 copayment per procedure, then 20%	$500 copayment per procedure, then 50%	Section 7.3
Spine surgery	$500 copayment per procedure, then 20%	$500 copayment per procedure, then 50%	Section 7.3
Uncomplicated hernia repair	$500 copayment per procedure, then 20%	$500 copayment per procedure, then 50%	Section 7.3
Gastric Bypass (Roux-en-Y) or Gastric Sleeve Centers of Excellence All other facilities	 $500 copayment, then 20% Not covered	 N/A Not covered	Section 7.10.1 Deductible applies Covered for subscriber only $20,000 Center of Excellence reference price (complications of a covered surgery are not subject to reference pricing)
Knee/Hip Replacement	$500 copayment, then 20%	50%	Section 7.9.5
Other Services			
Hospice & Palliative Care			Section 7.9.1 When palliative care diagnosis is billed in the primary position
Home Care	No cost sharing	50%	
Inpatient Care	No cost sharing	50%	
Respite Care	No cost sharing	50%	
Maternity	Treated same as any other condition.	Treated same as any other condition.	Section 7.9.2
Breastfeeding Support, Supplies and Counseling	No cost sharing	No cost sharing	Section 7.9.3 No cost share applies to most cost-effective options

Services	Cost Sharing (Deductible applies unless noted differently)		Section in Handbook and Details
	In-Network	Out-Of-Network	
Transplants			Section 7.9.4 Requires authorization.
Exclusive transplant network facilities	20%	N/A	
All other facilities	Not covered	Not covered	
Biofeedback	20%	50%	Section 7.9.6 10 visits
Home Healthcare	20%	50%	Section 7.9.7 Requires authorization. 140 visits per plan year
Outpatient Durable Medical Equipment	20%	50%	Section 7.9.8 Requires authorization. One wheelchair per plan year under age 19 and every 3 plan years age 19+.
Supplies and Appliances	20%	50%	Section 7.9.8 $1,800 reference price per oral appliance
Disposable Supplies (in a professional provider's office)	20%	50%	Section 7.9.8
Medications			
Prescription Medications			Section 7.12 May require authorization
Retail Pharmacy			
Value Tier	No copayment	No copayment	90-day supply per prescription available (3 times copayment applies)
Select Generic Tier	$8 per prescription	$8 per prescription	90-day supply per prescription available (3 times copayment applies)
Preferred Tier	25% up to $50 maximum per prescription	25% up to $50 maximum per prescription	31-day supply per prescription
Non-Preferred Brand Tier	50% up to $150 maximum per prescription	50%up to $150 maximum per prescription	31-day supply per prescription

Services	Cost Sharing (Deductible applies unless noted differently)		Section in Handbook and Details
	In-Network	Out-Of-Network	
Mail Order Pharmacy			90-day supply per prescription
Value Tier	No copayment	N/A	
Select Generic Tier	$16 per prescription	N/A	
Preferred Tier	25% up to $100 maximum per prescription	N/A	
Non-Preferred Brand Tier	50% up to $300 maximum per prescription	N/A	
Specialty Pharmacy			31-day supply per prescription Prior authorization required
Select Generic Tier	$16 per prescription	N/A	
Preferred Tier	25% up to $100 maximum per prescription	N/A	
Non-Preferred Brand Tier	50% up to $300 maximum per prescription	N/A	

2.3 DEDUCTIBLES

The Plan has a plan year deductible. The deductible is the amount of covered expenses that are paid by each member before benefits are payable by the Plan. The amount of the deductible is shown in section 2.2. Covered services, whether performed in-network or out-of-network, accumulate toward the plan year deductible. No family will be required to satisfy more than the total family deductible as shown in section 2.2, no matter how many members are in the family. After the deductible has been satisfied, benefits will be paid according to section 2.2. Expenses applied toward the plan year deductible apply towards the out-of-pocket maximum.

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

If a member does not meet their deductible during a plan year, any expenses applied to their deductible during the last 3 months of a plan year will be carried over and applied to the deductible for the following plan year.

Deductibles are accumulated on a plan year basis.

2.4 PLAN YEAR MAXIMUM OUT-OF-POCKET

After the plan year per member or per family plan out-of-pocket maximum is met, the Plan will pay 100% of covered services for the remainder of the plan year. Services accumulated toward the in-network out-of-pocket maximum can be used to satisfy both the in-network and out-of-network out-of-pocket maximum. Services accumulated toward the out-of-network out-of-pocket maximum cannot be used to satisfy the in-network out-of-pocket maximum.

Out-of-pocket costs are accumulated on a plan year basis.

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

a. The out-of-pocket expenses for prescription medications
b. The out-of-pocket expenses for bariatric surgery not performed at a Center of Excellence facility, or out-of-pocket expenses above the Center of Excellence $20,000 reference price
c. The out-of-pocket expense for an oral appliance above the $1,800 reference price per appliance
d. Additional cost tier copayment
e. Cost containment penalties
f. Disallowed charges

2.5 MAXIMUM COST SHARE

The maximum cost share includes additional cost tier copayments, pharmacy copayments and coinsurance as well as the eligible medical expenses that accrue toward the in-network out-of-pocket maximum. After a per member or per family plan year maximum cost sharing is met, the Plan will pay 100% of in-network covered essential health benefits for the remainder of the plan year.

The maximum cost share is different from the out-of-pocket maximums and can only be met by cost sharing for in-network covered expenses.

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

a. Services in excess of any maximum
b. Fees in excess of maximum plan allowance
c. Premiums or penalties
d. Disallowed charges
e. Expenses that apply toward the out-of-network out-of-pocket

2.6 PAYMENT

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

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

SECTION 3 COST CONTAINMENT

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

3.1 PRIOR AUTHORIZATION REQUIREMENTS

When a professional provider suggests admission to the hospital or a residential program, or a non-emergency surgery, the member should ask the provider to contact Moda Health for prior authorization.

The hospital, professional provider and member are notified of the outcome of the authorization process by letter.

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

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

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

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

3.1.1 Inpatient Services and Residential Programs

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

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

3.1.2 Ambulatory Surgery and Other Outpatient Services

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

3.1.3 Prescription Medication

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

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

3.2 SECOND OPINION

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

3.3 COST EFFECTIVENESS SERVICES

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

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

SECTION 4 CARE COORDINATION

4.1 CARE COORDINATION

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

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

4.2 DISEASE MANAGEMENT/HEALTH COACHING

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

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

If calling from Portland area 503-243-3957
Outside the Portland area.....800-913-4957

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

SECTION 5 DEFINITIONS

Terms used but not otherwise defined in this handbook shall have the same meaning as those terms in the OEBB Administrative Rules.

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

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

Authorization see Prior Authorization.

Autism Spectrum Disorder refers to the meaning as provided in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) published by the American Psychiatric Association.

Chemical Dependency (including alcoholism) means a substance-related disorder, as defined by the current edition of the Diagnostic and Statistical Manual of Mental Disorders, except for those related to foods, tobacco, or tobacco products.

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

Claim Determination Period means the plan year or portion thereof commencing October 1 of any calendar year and ending September 30 of the subsequent calendar year.

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

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

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

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

Creditable Coverage means a member's prior healthcare coverage including coverage remaining in force at the time a member obtains new coverage, as defined in Federal Code §9801(c)(1).

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

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

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

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

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

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

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

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

Experimental or Investigational means services and supplies that:

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

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

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

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

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

Implant means a material inserted or grafted into tissue.

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

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

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

MPA for an out-of-network provider other than a facility is the lesser of the amount payable under any supplemental provider fee arrangements Moda Health may have in place and the 75th percentile of fees commonly charged for a given procedure in a given area, based on a national database. If a dollar value is not available in the national database, Moda Health will consider 75% of the billed charge as the MPA. In certain instances, when a dollar value is not available in the database, the claim is reviewed by Moda Health's medical consultant, who determines a comparable code to the one billed. Once a comparable code is established, the claim is processed as described above.

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

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

MPA for implanted medical devices is the contracted amount, or the acquisition cost of the device plus 10% if there is no contracted amount.

MPA for end-stage renal disease (ESRD) facilities is 125% of the Medicare allowable amount.

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

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

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

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

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

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

Medically necessary care does not include custodial care.

The fact that a provider prescribes, orders, recommends, or approves a service or supply does not, of itself, make the service medically necessary or a covered service. More information regarding medical necessity can be found in General Exclusions (section 8).

Member means and includes the subscriber, spouse, eligible domestic partner or child.

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

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

Mental Illness means all disorders listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders except for:

a. Intellectual disability
b. Learning disorders
c. Paraphilias
d. V-Codes, (this exception does not extend to members 5 years of age or younger for diagnostic codes V61.20, V61.21, and V62.82)

Moda Health refers to Moda Health Plan, Inc.

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

Moda Medical Home means of a group of primary care professionals that are contracted under Moda Health to provide care to members (section 6.2). Moda medical homes provide in-network services in their specific service areas. Covered medical expenses will be paid at a higher rate when a Moda Medical Home physician or provider is used (see section 2.2).

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

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

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

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

The **Plan** is the health benefit plan sponsored by OEBB and insured under the terms of the policy between OEBB and Moda Health as described in the member handbook.

Plan Year refers to the twelve month period beginning October 1st and ending September 30th. All deductibles, maximums and limitations shall be accrued on a plan year basis.

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

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

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

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

Prosthetic Device as required by state law means an artificial limb device or appliance designed to replace in whole or in part an arm, leg, eye or other body part.

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

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

The Plan's **Service Area** is the geographical area of Benton, Clackamas, Clark, Clatsop, Columbia, Hood River, Jackson, Josephine, Klamath, Lane, Lincoln, Linn, Marion, Multnomah, Polk, Tillamook, Wasco, Washington and Yamhill counties where in-network providers provide their services.

Subscriber means any eligible employee or early retiree who is enrolled in the Plan.

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

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

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

SECTION 6 MEDICAL HOMES

6.1 MEDICAL HOMES

The Plan provides the highest benefit level for services provided by medical home providers. At enrollment, members are required to select a primary care provider from the medical homes. Members may find a medical home provider by using “Find Care” on myModa or by contacting Customer Service for assistance or through the myOEBB enrollment system.

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

If a member does not select and properly utilize the services of a medical home provider, claims will be paid at the out-of-network benefit level. Members who did not select a medical home provider at the time of enrollment application will need to inform Moda Health of the selection prior to receiving treatment.

6.2 MEDICAL HOME PRIMARY CARE PROVIDER

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

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

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

In order to change medical home primary care provider, members must notify Moda Health either in writing or by contacting Customer Service before obtaining treatment from a new medical home primary care provider.

6.3 OTHER MEDICAL HOME PROVIDER CARE

Members may use any network provider referred to them by a medical home primary care provider. If members do not use their selected medical home provider for primary care services, benefits will be paid at the out-of-network benefit level.

A member may see an in-network participating women's healthcare provider without referral from the medical home primary care provider for preventive women's health exams and other gynecological care, and for pregnancy care and still receive the in-network benefit level. Members do not need a referral from the medical home provider for routine exams for men, routine colorectal cancer screening, emergency treatment and mental health and/or chemical dependency treatment. However, there are prior authorization requirements on certain services (see section 3.1).

6.4 OUT-OF-NETWORK PROVIDER CARE

Services by a an out-of-network provider must be referred by the medical home primary care provider, authorized by Moda Health, and not available in the network in order for the in-network benefit level to apply. Moda Health will work with the medical home primary care provider to refer members to in-network providers whenever possible, because these providers have agreed to cooperate in Moda Health's quality assurance and utilization review programs. Payment for services rendered by non-medical home providers will be based on the maximum plan allowance for those services. Members will be responsible for the copayment or coinsurance and any amount in excess of the maximum plan allowance.

Members do not need a referral from the medical home primary care provider for preventive women's health exams and mental health and/or chemical dependency treatment. However, there are prior authorization requirements on certain services (see section 3.1).

6.5 EMERGENCY CARE

Claims for emergency care will be paid at the in-network benefit level, even without a referral by the medical home primary care provider or authorization by Moda Health. Emergency care rendered by a provider other than the medical home primary care provider should be reported to the medical home primary care provider within 24 hours of initial treatment, or as soon as possible. When the medical home primary care provider is out of the office, another medical home provider will be on call to assist members. See section 7.4 for more information.

6.6 CONTINUITY OF CARE

6.6.1 Continuity of Care

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

Moda Health will provide continuity of care if a medical services contract or other contract for a professional provider's services is terminated, the provider no longer participates in the network, and the Plan does not cover services when services are provided to members by the professional provider or covers services at a benefit level below the benefit level specified in the Plan for out-of-network professional providers.

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

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

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

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

a. The professional provider has relocated out of the service area or is prevented from continuing to care for patients because of other circumstances:

b. The contractual relationship has terminated in accordance with provisions of the medical services contract relating to quality of care and all contractual appeal rights of the professional provider have been exhausted

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

6.6.2 Length of Continuity of Care

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

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

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

a. The 45th day after the birth

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

6.6.3 Notice Requirement

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

If the professional provider belongs to a provider group, the provider group may deliver the notice if the notice clearly provides the information that the Plan is required to provide to the affected members.

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

SECTION 7 BENEFIT DESCRIPTION

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

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

7.1 MEMBERSHIP CARD

After enrollment, members will receive identification cards that will include the group and identification numbers. Members will need to present the card each time they receive services.

Members may go to myModa or contact Customer Service for replacement of a lost identification card. Identification cards can be accessed via a smart phone.

7.2 WHEN BENEFITS ARE AVAILABLE

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

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

When a member is a hospital inpatient on the day coverage ends, the Plan will continue to pay claims for covered services for that hospitalization until the member is discharged from the hospital.

7.3 ADDITIONAL COST TIER

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

$100 cost tier:

a. Upper endoscopy
b. Spinal injections
c. Viscosupplementation
d. Lumbar discography
e. Tonsillectomy for a member under age 18 with chronic tonsillitis or sleep apnea
f. Sleep studies
g. Imaging procedures

$500 cost tier:

a. Arthroscopy (knee and shoulder)
b. Hip replacement
c. Knee replacement
d. Spine surgery
e. Uncomplicated hernia repair
f. Knee / Hip Replacement (see section 7.9.5 for additional information including limitations)

Visit myModa or contact Customer Service for more information regarding the Additional Cost Tier.

7.4 EMERGENCY CARE

Members are covered for treatment of emergency medical conditions worldwide. A member who believes he or she has a medical emergency should call 9-1-1 or seek care from the nearest appropriate provider, such as a provider's office or clinic, urgent care facility or emergency room. All emergency room services will be reimbursed at the in-network benefit level. However, out-of-network providers may bill members for charges in excess of the maximum plan allowance and out-of-pocket maximum will apply. The emergency room facility copayment applies to services billed by the facility. Professional fees (e.g., emergency room physician, or x-ray/lab) billed separately are subject to the standard in-network benefit level. If a covered hospitalization immediately follows emergency services, emergency room facility copayments will be waived. All other applicable cost sharing remains in effect.

Prior authorization is not required for emergency medical screening exams or treatment to stabilize an emergency medical condition. Prior authorization is also not required for emergency services provided by an out-of-network provider when a prudent layperson possessing an average knowledge of health and medicine would reasonably believe that the time required to go to an in-network provider would place the health of the member, or a fetus in the case of a pregnant woman, in serious jeopardy.

7.4.1 Emergencies Within the Service Area

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

Certain medical emergencies may prevent members from initially seeking care through their medical home primary care provider. If a member requires immediate medical assistance due to an emergency medical condition, and believes the delay caused by contacting the medical home primary care provider will jeopardize their health, they should seek care from the nearest appropriate facility or call 9-1-1. They should call the medical home primary care provider within 24 hours of the initial medical care, or as soon thereafter as possible. Self-directed routine healthcare rendered in a hospital emergency room will be paid at the out-of-network benefit level.

7.4.2 Emergencies and Urgent Care Outside the Service Area

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

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

The in-network benefit level will not be available for out-of-network care other than emergency medical care, unless a member's medical home primary care provider has requested a prior authorization which has been approved by Moda Health, and service is not available in the Moda Health network. The following are not emergency medical conditions and are not eligible for the in-network benefit level (this list is not inclusive of all such services):

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

7.5 AMBULANCE TRANSPORTATION

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

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

7.6 HOSPITAL & RESIDENTIAL FACILITY CARE

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

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

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

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

7.6.1 Emergency Room Care

Medically necessary emergency room care is covered. See section 7.4 for more information.

7.6.2 Pre-admission Testing

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

7.6.3 Hospital Benefits

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

a. **Hospital room.** The actual daily charge, not to exceed the hospital's most common rate for a 2-bed room
b. **Isolation care.** When the Plan agrees it is necessary to protect other patients from contagion or to protect a member from contracting the illness of another person
c. **Intensive care unit**. Using generally recognized industry standards as a guide, the Plan reserves the right to decide whether a unit in a particular hospital qualifies as an intensive care unit
d. **Facility charges.** For surgery performed in a hospital outpatient department
e. **Other hospital services and supplies.** Those necessary for treatment and ordinarily furnished by a hospital
f. **Routine nursery care.** Including one in-nursery provider’s visit of a well newborn infant while the mother is confined in the hospital and receiving maternity benefits under the Plan. The deductible is waived for routine nursery care (Routine nursery care received out of network is subject to out-of-network benefits.)

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

An authorized hospitalization in an out-of-network facility will be covered at the benefit level shown in section 2.2 for the type(s) of covered services rendered, including the application of cost sharing and fee schedule limitations.

In a medical emergency, the in-network level of benefits will be paid to an out-of-network facility until the member can be safely transported to an in-network facility for continued hospitalization. Members declining transport to an in-network facility will receive the lower out-of-network benefits for that hospitalization and all concurrent out-of-network provider care.

Inpatient services, other than emergency care, must be authorized by Moda Health. Medically necessary hospital admissions not authorized by Moda Health are paid at the out-of-network benefit level even if the facility is an in-network provider. If the hospital stay is not medically necessary, claims will be denied.

7.6.4 Inpatient Rehabilitative Care

Covered rehabilitative care expenses are subject to a plan year limit for inpatient services delivered in a hospital or other inpatient rehabilitation facility that specializes in such care. Additional days may be available for treatment required following head or spinal cord injury, subject to medical necessity and prior authorization.

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

7.6.5 Skilled Nursing Facility Care

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

Covered skilled nursing facility days are subject to a plan year limit and medical necessity.

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

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

a. Senile deterioration
b. Alzheimer's disease

c. Mental deficiency or intellectual disability in members age 18 or older
d. Mental illness

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

7.6.6 Residential Mental Health and Chemical Dependency Treatment Programs

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

7.6.7 Chemical Dependency Detoxification Program

All-inclusive daily charge for room and treatment services by a treatment program that meets the definitions in the Plan, subject to medical necessity.

7.7 AMBULATORY SERVICES

Many ambulatory services require prior authorization (see section 3.1). If a medically necessary service is not arranged through a primary care physician and is not authorized by Moda Health, members will receive out-of-network benefits even if they utilize in-network providers.

7.7.1 Outpatient Surgery

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

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

7.7.2 Outpatient Rehabilitation

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

Outpatient rehabilitative services are short term in nature with the expectation that the member's condition will improve in a reasonable and generally predictable period of time.

Therapy performed to maintain a current level of functioning without documentation of improvement is considered maintenance therapy and is not covered. Maintenance programs that prevent regression of a condition or function are not covered. This benefit also does not cover recreational or educational therapy, educational testing or training, non-medical self-help or training, services related to treatment, testing or training for learning disabilities, testing or treatment for mental retardation for members age 18 or older, or hippotherapy.

7.7.3 Infusion Therapy

The Plan covers infusion therapy services and supplies when prior authorized, and ordered by a professional provider as a part of an infusion therapy regimen.

Home infusion therapy must be provided by an accredited home infusion therapy agency. In addition, members receiving the services must qualify as "homebound" (as defined in section 7.9.7). Members receiving treatment, for services other than chemotherapy, through Coram Home Infusion will have both deductible and coinsurance waived.

Infusion therapy benefits are limited to the following:

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

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

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

7.7.4 Diagnostic X-rays and Laboratory Tests

The Plan covers diagnostic x-rays and laboratory tests related to treatment of a medical condition. Members receiving treatment through Quest Labs will have both deductible and coinsurance waived.

7.7.5 Radium, Radioisotopic, X-ray Therapy, and Kidney Dialysis

Covered expenses include:

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

Members with end-stage renal disease (ESRD) are encouraged to enroll in Medicare Part B.

7.7.6 Imaging Procedures

The Plan covers all standard imaging procedures when medically necessary and related to treatment of a medical condition.

The following advanced imaging services require prior authorization:

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

7.7.7 Outpatient Chemical Dependency Services

Services for assessment and treatment of chemical dependency in an outpatient treatment program are covered.

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

7.7.8 Routine Costs in Clinical Trials

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

Qualified clinical trials are limited to those:

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

The Plan does not cover items or services:

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

7.8 PROFESSIONAL PROVIDER SERVICES

7.8.1 Preventive Healthcare

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

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

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

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

There are additional preventive healthcare services for which the Plan will waive the deductible and any copayments and cover when performed by an in-network provider, referred by the primary care physician and billed with a routine diagnosis. Services billed with a medical diagnosis are paid at the standard benefit level.

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

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

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

    Exams for licensing or employment purposes, participating in sports or other activities do not constitute periodic health exams and are not covered. An exam to rule out a diagnosis of illness based on family history is eligible for benefits as a periodic health exam based on the above schedule.

    Routine diagnostic x-ray and lab work related to a periodic health exam are also covered.

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

c. Cardiovascular screenings. One Electrocardiogram (EKG) and treadmill test when performed in conjunction with a covered periodic health exam.

d. Hearing evaluation. Hearing evaluations for newborns and when performed in conjunction with a covered well-child examination. Hearing evaluations for adults when performed in conjunction with an adult periodic health exam.

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

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

Breast exams are limited to women 18 years of age and older. Mammograms are limited to one between the ages of 35 and 39 and one per plan year age 40 and older.

Pap tests, breast exams, and mammograms for the purpose of diagnosis in symptomatic or designated high risk women, are also covered when deemed necessary by a professional provider. These services covered under the office visit, x-ray or lab test benefit level if not performed for preventive purposes.

Breast cancer (BRCA) testing coverage for preventive screening, genetic counseling and genetic testing at no cost sharing.

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

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

h. Colorectal Cancer Screening. The following, including related charges, when recommended by the treating professional provider:

    i. Routine flexible sigmoidoscopy and pre-surgical exam or consultation

    ii. Routine colonoscopy, including polyp removal and pre-surgical exam or consultation and related anesthesia

    iii. Double contrast barium enema

    iv. Fecal occult blood test

    Laboratory tests are covered at the medical benefit level. Colorectal cancer screening is covered at the medical benefit level if it is not performed for preventive purposes (e.g., screening is for diagnostic reasons or to check symptoms). General anesthesia is covered at the benefit level of the related colorectal cancer screening if medically necessary. Otherwise, it is not covered.

i. A wellness visit applies to members who are age 21 and older, and shall include a comprehensive medical evaluation including an age and gender appropriate history, family medical history, examination, counseling, anticipatory guidance, and risk factor reduction intervention. The medical evaluation may include assessment of and counseling for BMI, nutrition and diet, activity and blood pressure.

7.8.2 Contraception

All FDA-approved contraceptive methods and counseling are covered when prescribed by a professional provider. Women's contraception, when utilizing the most cost effective option (e.g., generic instead of brand name), will be covered with no cost sharing to the member.

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

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

7.8.4 Diabetes Self-Management Programs

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

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

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

7.8.5 Therapeutic Injections

Administrative services for therapeutic injections, such as allergy shots, are covered when given in a professional provider's office. When comparable results can be obtained safely with home self-care, or through oral use of a prescription drug, administrative services for therapeutic injections are not covered. (Additional information in section 7.11.1).

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

7.8.6 Surgery

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

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

The services listed above are paid at the surgery copayment or coinsurance level.

Surgical services approved by a primary care provider must be prior authorized by Moda Health. Benefits for any services not arranged through a primary care provider will be paid at the out-of-network benefit level.

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

7.8.7 Reconstructive Surgery Following a Mastectomy

As used in this section (Women's Health and Cancer Rights Act), mastectomy means the surgical removal of all or part of a breast, including a breast tumor suspected to be malignant. The Plan covers reconstructive surgery following a covered mastectomy:

a. All stages of reconstruction of the breast on which the mastectomy has been performed, including nipple reconstruction, skin grafts and stippling of the nipple and areola
b. Surgery and reconstruction of the other breast to produce a symmetrical appearance
c. Prostheses
d. Treatment of physical complications of the mastectomy, including lymphedemas
e. Inpatient care related to the mastectomy and post-mastectomy services

This coverage will be provided in consultation with the member's attending provider and will be subject to the same terms and conditions, including the prior authorization and cost sharing provisions otherwise applicable under the Plan.

7.8.8 Cosmetic and Reconstructive Surgery

Cosmetic surgery is surgery that improves or changes appearance without restoring impaired body function. Reconstructive surgery is surgery performed on abnormal structures of the

body, caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease. It is usually performed to improve function, but may also be performed to approximate a normal appearance.

Cosmetic surgery is not covered. Reconstructive procedures that are partially cosmetic in nature may be covered if Moda Health's medical director finds the procedure to be medically necessary. All reconstructive procedures must be medically necessary and prior authorized or benefits will not be paid.

Coverage is also available for the following services if prior authorized and medically necessary:

a. Surgery to reduce breast size
b. Surgical repair of congenital deformities

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

Surgery for breast augmentation, achieving breast symmetry, and replacing breast implants (prosthetics) to accomplish an alteration in breast contour or size are not covered except as provided in section 7.8.7.

7.8.9 Gender Dysphoria Services

Gender dysphoria refers to discomfort or distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics). Gender nonconformity refers to the extent to which a person's gender identity or expression differs from the cultural norms prescribed for people of a particular sex.

The Plan covers expenses for gender reassignment under the following conditions:

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

Coverage includes:

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

7.8.9.1 Gender Dysphoria Criteria:

The current DSM 5 criteria for gender dysphoria include:

a. A marked incongruence between one's experience/expressed gender and assigned gender of at least 6 months duration, as manifested by 2 or more of the following indicators
    i. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristic (or, in young adolescents, the anticipated sex characteristics)
    ii. A strong desire to be rid of one's primary or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or, in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics)
    iii. A strong desire for the primary and/or secondary sex characteristics of the other gender (or some alternative gender from the one's assigned gender)
    iv. A strong desire to be treated as the other gender (or some alternative gender from one's assigned gender)
    v. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender)
b. The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning, or with a significantly increased risk of suffering, such as distress or disability.

Treatment of severe, persistent gender dysphoria includes a variety of therapeutic options. The number and type of interventions applied and the order in which they take place may differ from person to person. Treatment options include changes in gender expression and role, hormone therapy to feminize or masculinize the body, surgery to change primary and/or secondary sex characteristics, and psychotherapy for purposes such as explore gender identity which may include individual, couple, family, or group.

Gender reassignment surgery is not one procedure but a complex process that involves multiple steps over a period of time with careful psychological and medical evaluations prior to initiation of each modality of treatment. It is a multidisciplinary process involving psychological, medical and surgical treatments all performed in conjunction with each other to assist the individual to achieve the desired successful outcome.

7.8.9.2 Treatment Criteria

a. Psychological therapy is considered medically necessary with ALL of the following:
    i. Mental health professional providing treatment is experienced with diagnosis and treatment of gender dysphoria
    ii. Health professional has a Master's degree or higher in a clinical behavioral science field
    iii. Member has expressed discomfort with assigned gender and desire to explore treatment options

iv. Member and licensed behavioral health professional are able to screen/identify and treat co-existing mental health concerns which may include depression, anxiety, self-harm, substance abuse, sexual concerns, personality disorders, psychotic disorders, and autistic spectrum disorders

b. Hormone therapy is considered medically appropriate for ALL of the following:
   i. Referral from licensed behavioral/mental health professional who has performed assessment and recommending feminizing/masculinizing hormone therapy
   ii. Persistent, well-documented gender dysphoria
   iii. Capacity to make a fully informed decision and to consent for treatment
   iv. Age of majority (18 years of age or older)
   v. If significant medical or mental health concerns are present, they must be reasonably well-controlled.

c. Breast/chest surgery for Female-to-Male (FtM) members is medically appropriate with ALL of the following (Hormone therapy is not a prerequisite)
   i. One referral from qualified behavioral/mental health professional for referral letter requirements)
   ii. Persistent, well-documented gender dysphoria
   iii. Age of majority (18 years of age or older)
   iv. If significant medical or mental health concerns are present, they must be reasonably well controlled.

d. Gonadectomy (hysterectomy/oophorectomy for Female-to-Male (FtM) or orchiectomy for Male-to-Female (MtF) is considered medically appropriate with ALL of the following:
   i. Two referrals from qualified behavioral/mental health professionals
   ii. Persistent, well documented gender dysphoria
   iii. Age of majority (18 years or older)
   iv. 12 continuous months of hormone therapy as appropriate to the member's gender goals (unless hormones are not clinically indicated for the individual)

e. Gender reassignment surgery (metoidioplasty or phalloplasty in FtM and vaginoplasty for MtF) is considered medically appropriate for ALL of the following:
   i. Two referrals from licensed behavioral/mental health professionals
   ii. Persistent, well-documented gender dysphoria
   iii. Capacity to make a fully informed decision and to consent for treatment
   iv. Age of majority (18 years of age or older)
   v. If significant medical or mental health concerns are present, they must be well controlled
   vi. 12 months of continuous hormone therapy as appropriate to the member's gender goals (unless hormones are not clinically indicated for the individual).
   vii. 12 continuous months of living in a gender role that is congruent with the member's identity

f. Treatment of the Adolescent with gender dysphoria may
    i. Psychological assessment of children or adolescents who present with gender dysphoria includes ALL of the following
        A. Assessment and guidance is provided by a qualified mental health professional trained in childhood and adolescent psychopatholgy and competent in diagnosing in a multidisciplinary setting or in consultation with a pediatric endocrinologist.
        B. Provides family counseling and supportive psychotherapy to assist the child or adolescent with exploring their gender identity
        C. Assess and treat any coexisting mental health concerns of children and adolescents and address them as part of the overall treatment plan
        D. Refer adolescents for additional physical interventions (such as puberty-suppressing hormones) with the appropriate documentation of assessment of gender dysphoria and mental health.
        E. Ability to educate and advocate on behalf of the gender dysphoric child, adolescent, and their family in their community.
        F. Provide information and referral for peer support and support groups for parents of gender-nonconforming and transgender children.

    ii. Reversible therapy with puberty-suppressing hormones are medically appropriate with ALL of the following
        A. The adolescent has demonstrated a long-lasting and intense pattern of gender nonconformity or gender dysphoria (whether suppressed or expressed)
        B. Gender dysphoria emerged or worsened with the onset of puberty
        C. The member has experienced the onset of puberty to at least Tanner Stage 2.(2)
        D. Any coexisting psychological, medical, or social problems that could interfere with treatment (e.g. may compromise adherence with treatment) have been addressed such that the adolescent's situation and functioning are stable enough to start treatment
        E. The adolescent has given informed consent, and particularly when the adolescent has not reached the age of medical consent, the parents or other caretakers or guardians have consented to the treatment and are involved in supporting the adolescent throughout the treatment process.

    iii. Partially reversible interventions with feminizing/masculinizing hormone therapy is medically appropriate with ALL of the following
        A. The adolescent has demonstrated a long lasting and intense pattern of gender non-conformity or gender dysphoria
        B. The adolescent has been referred by a qualified mental health professional or has been undergoing treatment with a Pediatric Endocrinologist for puberty-suppressing hormones.

C. The adolescent has given informed consent if the age of medical consent and particularly when the adolescent has not reached the age of medical consent, the parents or other caretakers or guardians have consented to the treatment and are involved in supporting the adolescent throughout the treatment process.
D. The adolescent has been compliant with puberty-suppressing hormone therapy
E. Any coexisting psychological, medical, or social problems that could interfere with treatment (e.g. may compromise adherence with treatment) have been addressed such that the adolescent's situation and functioning are stable enough to start treatment

iv. Genital surgery including gonadectomy and gender reassignment surgery is not covered for adolescents. Genital surgery should not be carried out until the patient reaches the age of majority (18 years of age or older), has lived continuously for at least 12 moths in the gender role that is congruent with their gender identity, and meets the additional criteria for surgical procedures for adults with gender dysphoria.

v. Chest surgery in FtM adolescent patients may be carried out prior to 18 with ALL of the following
A. Meets all of the criteria for treatment of adolescent with puberty-suppressing hormones and masculinizing hormones
B. Reached the age of medical consent
C. Had ample time (preferably one year) living in the desired gender role
D. Undergone one year of testosterone treatment.

7.8.9.3 Exclusions

a. The following procedures are considered cosmetic and not covered for gender reassignment.
i. Abdominoplasty
ii. Blepharoplasty
iii. Breast augmentation procedures including mammoplasty, implants and silicone injections
iv. Chin/nose implants
v. Collagen injections
vi. Electrolysis
vii. Face/forehead lift
viii. Brow lift
ix. Calf Implants
x. Cheek implants
xi. Fertility services/Cryopreservation of sperm/embryos
xii. Hair removal/hair transplantation
xiii. Jaw shortening/sculpturing/facial bone reduction
xiv. Laryngoplasty

xv. Lip reduction/enhancement
xvi. Liposuction
xvii. Mastopexy
xviii. Neck tightening
xix. Nipple/areola reconstruction/tattooing
xx. Removal of redundant skin
xxi. Rhinoplasty
xxii. Skin resurfacing
xxiii. Trachea shave/reduction thyroid chondroplasty
xxiv. Voice modification
xxv. Voice therapy/voice lessons

b. Reversal, revision, or removal of gender reassignment surgery is NOT covered. Medical or surgical complications may be covered if determined to be medically necessary to stabilize even if the original surgery was not a covered benefit.

7.8.10 Cochlear Implants

Cochlear implants are covered when medically necessary and prior authorized.

7.8.11 Inborn Errors of Metabolism

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

7.8.12 Special Dental Care

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

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

If a member chooses to have tooth implant placement as the restoration choice following a covered dental accident, the allowed amount will be limited to that which would have been allowed for a crown, bridge, or partial. Removal of tooth implants or attachments to tooth implants are not covered.

The Plan only covers treatment within 12 months of the date of injury. Covered treatment is limited to that which will restore teeth to a functional state. Exceptions to the timelines may be made when medically necessary.

7.8.13 Maxillofacial Prosthetic Services

The Plan covers maxillofacial prosthetic services considered necessary for restoration and management of head and facial structures that cannot be replaced with living tissue and that are defective because of disease, trauma or birth and developmental deformities when such restoration and management are performed for the purpose of:

a. Controlling or eliminating infection
b. Controlling or eliminating pain
c. Restoring facial configuration or functions such as speech, swallowing or chewing but not including cosmetic procedures rendered to improve on the normal range of conditions

7.8.14 Temporomandibular Joint Syndrome (TMJ)

TMJ-related surgical procedures and splints require prior authorization, and are covered only when medically necessary as established by a history of arthritic degeneration documented in a patient's medical record, or in cases involving severe acute trauma. Treatment of related dental diseases or injuries is excluded.

7.8.15 Mental Health

The Plan covers medically necessary outpatient services by a mental health provider as defined in section 5.

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

7.8.16 Podiatry Services

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

7.8.17 Tobacco Cessation

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

A tobacco cessation program means a professional provider offering an overall treatment program that follows the United States Public Health Service guidelines for tobacco use cessation.

Members may contact Customer Service to locate an exclusive tobacco cessation program.

7.8.18 Telemedical Health Services

Covered medical services, delivered through a 2-way video communication that allows a professional provider to interact with a member who is at an originating site, are covered. Benefits are subject to the applicable cost sharing for the covered medical services.

An originating site includes the following:

a. Hospital
b. Rural health clinic
c. Federally qualified health center
d. Provider's office
e. Community mental health center
f. Skilled nursing facility
g. Renal dialysis center
h. Site where public health services are provided

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

7.8.19 Alternative Care

Alternative care is chiropractic, naturopathic, and acupuncture services.

To be covered, alternative care must be within the scope of the professional provider's license. It also must not be specifically excluded under the Plan.

A referral from a primary care provider is not required for treatment by an alternative care provider.

Lab and diagnostic x-rays ordered by a chiropractor or naturopath are subject to the Plan's standard reimbursement rate for lab and diagnostic x-rays.

Prescribed office supplies and substances approved by the Board of Naturopathic Examiners and dispensed by a professional provider are covered.

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

There is an aggregate plan year maximum for alternative care services. Reimbursement for other services is at the Plan's standard cost sharing for the type of service rendered.

7.8.20 Treatment for Autism Spectrum Disorder

The Plan covers medically necessary treatment for autism spectrum disorder and the management of care provided in the member's home or a licensed health care facility. Prior authorization and submission of an individualized treatment plan are required.

Coverage includes:

a. Screening for and diagnosis of autism spectrum disorder by a licensed neurologist, pediatric neurologist, developmental pediatrician, psychiatrist or psychologist, who has experience or training in the diagnosis of autism spectrum disorder.
b. Applied behavior analysis and any other mental health or medical services identified in the treatment plan as provided by a professional provider licensed under the Behavioral Analysis Regulatory Board

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

Treatment for autism spectrum disorder does not include:

a. Services provided by a family or household member
b. Services that are custodial or that constitute marital, family, educational or training services
c. Custodial or respite care, equine assisted therapy, creative arts therapy, wilderness or adventure camps, social counseling, telemedicine, music therapy, neurofeedback, chelation or hyperbaric chambers
d. Services provided under an individual education plan in accordance with the Individuals with Disabilities Education Act, 20 U.S.C 1400 et seq
e. Services provided through community or social programs
f. Services provided by the Department of Human Services or the Oregon Health Authority, other than employee benefit plans offered by the department and the authority

7.9 OTHER SERVICES

7.9.1 Hospice & Palliative Care

a. Definitions

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

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

Hospice treatment plan means a written plan of care established and periodically reviewed by the member's attending provider. The provider must certify in the plan that the member is terminally ill and the plan must describe the services and supplies for medically necessary or palliative care to be provided by the approved hospice.

The Plan covers the services and supplies listed below when included in a hospice treatment plan. Services must be provided by an approved hospice agency to a member who is terminally ill and not seeking further curative treatment.

b. 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 visit must be for intermittent medically necessary or palliative care.

c. Hospice Inpatient Care

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

d. Respite Care

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

The Plan covers respite care provided to a member who requires continuous assistance when arranged by the primary care physician and prior authorized by Moda Health. Hospice care is covered for services provided in the most appropriate setting.

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

e. Exclusions

In addition to exclusions listed in section 8 the following are not covered:

a. Hospice services provided to other than the terminally ill member, including bereavement counseling for family members

b. Services and supplies not included in the hospice treatment plan or not specifically listed as a hospice benefit

7.9.2 Maternity Care

Pregnancy care, childbirth and related conditions, including voluntary abortions are covered when rendered by a professional provider. Professional providers do not include midwives unless they are licensed and certified nurse midwives or certified nurse practitioner midwives. The Plan covers facility charges for maternity care when rendered at a covered facility, including a birthing center. (For routine OB-GYN treatment, a woman may see an in-network women's healthcare provider without referral from her primary care physician.) The Plan also covers professional fees for group prenatal classes are covered for female members who are pregnant.

Home birth expenses are not covered other than the fees billed by a professional provider. Additional information regarding home birth exclusions is in section 8.

Special Right Upon Childbirth (Newborns' and Mothers' Health Protection Act). Benefits for any hospital length of stay in connection with childbirth for the mother or newborn child will not be restricted to less than 48 hours following a normal vaginal delivery or 96 hours following a cesarean section, unless the mother's or newborn's attending professional provider, after consulting with the mother, chooses to discharge the mother or her newborn earlier. Prior authorization is not required for a length of stay up to these limits.

7.9.3 Breastfeeding Support

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

7.9.4 Transplants

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

a. Definitions

Exclusive Transplant Network Facility means a healthcare facility with which Moda Health has contracted or arranged to provide facility transplant services for participating organization's members.

Transplant means a procedure or series of procedures by which:

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

ii. Tissue is removed from one's body and later re-introduced back into the body of the same person

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

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

i. Transplant procedures must be performed at an exclusive transplant network facility. If an exclusive transplant facility cannot provide the necessary type of transplant, Moda Health will prior authorize services at an alternative transplant facility.
ii. If the recipient or self-donor is enrolled in the Plan, donor costs related to a covered transplant, including expenses for an enrolled donor resulting from complications and unforeseen effects of the donation, are covered. If the donor is enrolled in the Plan and the recipient is not enrolled or is in the exclusion period, the Plan will not pay any benefits toward donor costs. Expenses incurred by a donor not enrolled in the Plan that result from complications and unforeseen effects of the donation are not covered. "Donor costs" means the covered expense of removing the tissue from the donor's body and preserving or transporting it to the site where the transplant is performed as well as any other necessary charges directly related to locating and procuring the organ
iii. Professional provider transplant services are paid according to the benefits for professional providers
iv. Immunosuppressive medications provided during a hospital stay are paid as a medical supply. Outpatient oral and self-injectable prescription medications for transplant-related services are paid under the Prescription Medication section (see section 7.12)
vi. The Plan will not pay for chemotherapy with autologous or homogenic/allogenic bone marrow transplant for treatment of any type of cancer not approved for coverage

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

c. 24-Month Exclusion Period. Transplants will not be covered during the first 24 months a person is enrolled in the Plan except the 24-month exclusion period will not apply:.
i. If the member has been continuously enrolled in the Plan since birth
ii. If the member was continuously enrolled in the Plan together with the Group's prior plan at least 24 months prior to incurring transplant-related expenses. If the

member had applicable coverage under a prior health benefit plan, each day of creditable coverage the member had under that prior health benefit plan will reduce the 24-month exclusion period by one day

Moda Health will use the following sources to determine creditable coverage: certificates of creditable coverage, information given on the enrollment application, information from prior group health plans and insurers, and other available evidence. Any period of creditable coverage that is followed by a break in coverage of 63 days or more cannot be used to reduce the exclusion period. Any coverage waiting period imposed under a group health plan or policy, and any affiliation period imposed by an HMO, will not be counted toward the break in coverage. Members submitting a certificate of creditable coverage from a prior plan should submit all available certificates. Members may request a certificate of creditable coverage from a prior plan or insurer within 24 months of coverage termination.

7.9.5 Knee/Hip Replacement

7.9.6.1 Travel Benefit:

a. To qualify for lodging reimbursement, the member must live more than 120 miles from the surgery facility
b. Per diem and automobile mileage limitations based on federal government allowances from the US General Services Administration (GSA)
c. The Plan will reimburse up to $2,600 for qualifying travel and lodging expenses for the member and one guest

7.9.6 Biofeedback

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

7.9.7 Home Healthcare

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

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

a. a registered or licensed practical nurse
b. a physical, occupational, speech, or respiratory therapist
c. a licensed social worker

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

This benefit does not include home healthcare, home care services, or supplies provided as part of a hospice treatment plan. These are covered under section 7.9 and section 7.9.8.

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

Home healthcare requires prior authorization.

7.9.8 Supplies, Appliances and Durable Medical Equipment

Supplies

Includes:

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

Prosthetic and orthotic devices

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

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

Appliance

Items, including orthopedic braces, used for performing or facilitating the performance of a particular bodily function. Within 90 days following cataract surgery, one conventional intraocular lens or one contact lens or eyeglasses is covered for each eye operated on. However, the following are not covered: dental appliances and braces, supporting devices such as corsets, compression or therapeutic stockings except when such stockings are medically necessary, hearing aids except as stated in section 7.9.9, eye glasses and contact lenses except as otherwise covered by the Plan.

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

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

The Plan covers the rental charge (not to exceed the purchase price) for durable medical equipment. Upon request, members must authorize any supplier furnishing durable medical equipment to provide information related to the equipment order and any other records Moda Health requires to approve a claim payment. Purchase or maintenance expenses of a wheelchair (including scooters) are covered subject to a coverage limit.

Oral appliance
Expenses for an oral appliance are covered up to a per appliance reference price (section 2.2).

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

Exclusions
In addition to the exclusions listed in section 8, the Plan will not cover the following appliances and equipment, even if they relate to a condition that is otherwise covered by the Plan:

a. Those used primarily for comfort, convenience, or cosmetic purposes
b. Wigs and toupees
c. Those used for education or environmental control, such as ramps, hand rails, bath benches, telephones, humidifiers, air filters, air conditioners, heat lamps, tanning lights, whirlpools or hot tubs
d. Therapeutic devices, except for transcutaneous nerve stimulators
e. Incontinence supplies

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

7.9.9 Hearing Aids

The Plan covers one hearing aid per hearing impaired ear. Members must be examined by a physician before obtaining a hearing aid that is prescribed, fitted and dispensed by a licensed audiologist or hearing aid specialist.

Covered benefits include the following every 48 months:

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

Members ages 26 and over have a 48-month hearing aid maximum (section 2.2).

7.9.10 Nonprescription Enteral Formula For Home Use

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

7.10 Reference Price Program

In the reference price program a set price applies to bariatric surgery and oral appliances (section 2.2). If a member receives services from a provider who does not met the reference price, the member is responsible for the difference between the provider's charge and the reference price. Any amount above the reference price does not apply towards the plan year maximum out-of-pocket (section 2.4). If a member is unable to locate a provider who meets the reference price, or has concerns about the quality of services received from providers who meet the reference price, Customer Service should be contacted for assistance.

7.10.1 Gastric Bypass (Roux-en-Y) and Gastric Sleeve

Medically necessary bariatric surgery services, limited to the Roux-en-Y gastric bypass or gastric sleeve surgery, are covered for subscribers who meet all of the following requirements:

a. Are 18 years or older
b. Complete all the requirements listed under section 7.10.1.1 below prior to the surgery and no earlier than 6 months after the date coverage began
c. Meet the requirements as listed under section 7.10.1.2

7.10.1.1 Pre-Surgery Eligibility Requirements:

a. Medical and psychological evaluation
b. A modest weight loss of 5% over 6 months

c. Dietary counseling and evaluation
d. Documented participation in one of the following programs

    i. Minimum of 6 months participation in OEBB Weight Watchers Program or a recognized commercial behavioral weight management program. The treatment program must include hypocaloric diet changes, nutrition education, and physical activity and behavior change strategies
    ii. Minimum 6 months participation in a physician, nurse practitioner, physician assistant, registered dietician or licensed behavioral therapist-supervised weight loss program, with or without obesity pharmacotherapy
    iii. Three or more primary care visits over a minimum of 6 months with a weight management treatment plan in the medical record
    iv. Participation and completion of an 12-week health education weight management program

e. Medical record documentation that none of the previous weigh loss efforts have been sustained and sufficient to address the co-existing medical condition(s) and/or comorbid conditions applicable to the patient

7.10.1.2 Surgery Requirements

a. Body mass index (BMI) ≥35 with one or more co-existing conditions that can be life-threatening:

    i. Sleep apnea uncontrolled on Continuous Positive Airway Pressure (CPAP) or inability to use CPAP with an Apnea/Hypopnea Index (AHI) >15 on sleep study or inability to use CPAP with an AHI >5 and documentation of excessive daytime sleepiness, impaired cognition (ability to think clearly), mood disorders or insomnia, hypertension, ischemic heart disease, or history of stroke
    ii. Congestive heart failure (CHF) or cardiomyopathy with a recommendation for bariatric surgery from a participating physician who is a cardiologist
    iii. Obesity hypoventilation with PC02 ≥45 and a recommendation for bariatric surgery from a participating physician who is apulmonologist
    iv. Diabetes mellitus uncontrolled (HbA1c8 persistently above 7.5) with conventional medical therapy that includes insulin together with an insulin sensitizing oral agent *i.e.* metformin or pioglitazone (or documented intolerance to insulin or insulin sensitizing oral agents) or > 15 pound weight gain within 2 years of starting insulin therapy
    v. Severe hypertriglyceridemia (>1000 mg/dl) uncontrolled with conventional medical therapy that includes trial of at least two fibrate medications and therapeutic doses of omega-3 fatty acid (6 grams daily), as well as alcohol avoidance

vi. Hypertension (high blood pressure) with blood pressure >140/90 (130/80 in the presence of diabetes or renal (kidney) disease) documented on two consecutive visits despite use of three antihypertensive medications including a diuretic (increases urination), unless contraindicated
vii. Refractory extremity edema with ulceration documented by a participating physician.
viii. End-stage renal disease with difficulty dialyzing documented by a participating physician who is a nephrologist (kidney specialist)
ix. Pseudotumor cerebri documented by a participating physician who is a neurologist

b. BMI ≥40/ m2 with one or more of the above co-morbid conditions and/or have symptomatic degenerative (deteriorating) joint disease of hip, knee or ankle with abnormal x-rays
c. BMI ≥50/m2 (no co-morbid condition required)
d. BMI ≥ 60:
    i. For subscribers with a BMI ≥60 and/or subscribers 60 years of age or higher, surgical risk decisions regarding the appropriateness of surgery will be made individually based on rehabilitation potential and the participating provider's judgment regarding surgical risk and likelihood of benefit
    ii. For subscribers with a BMI between 60 and 70, decisions regarding surgical timing will be made individually based on rehabilitation potential and the participating provider's judgment regarding surgical risk and benefit
    iii. Surgery is not felt to be appropriate for extreme levels of obesity (BMI >70) and non-surgical strategies for weight loss will be recommended

7.10.1.3 Bariatric Surgery Services Limitations:

a. Services in section 7.10.1 are for subscribers only
b. Only Roux-en-Y gastric bypass or gastric sleeve surgery will be performed
c. Surgeries will only be performed at a defined network of Centers of Excellence
d. $20,000 facility reference price (see section 2.4). Complications are not subject to reference pricing
e. Subscribers not eligible for bariatric surgery are not eligible for coverage of complications

7.10.1.4 Definitions:

a. **Centers of Excellence** (COE) means a healthcare facility with which Moda Health has contracted or arranged to provide facility services for Roux-en-Y gastric bypass or gastric sleeve surgery for participating organization's members.

7.10.1.5 Travel Benefit:

a. To qualify, the subscriber must live more than 120 miles from a Center of Excellence
b. Per diem and mileage limitations based on federal government allowances from the US General Services Administration (GSA)

c. The Plan will reimburse up to $2,600 for qualifying expenses

Benefit includes:

Trips to COE	Maximum Nights	With Guest
Pre-surgery consultation	1	Yes
Surgery	6	Yes
One post Surgery follow-up*	1	Yes

*Additional post surgery trips will be covered if medically necessary.

7.11 MEDICATIONS

7.11.1 Medication Administered by Provider, Infusion Center or Home Infusion

A medication that is given by injection or infusion (intravenous administration) in the professional provider's office, infusion center or home infusion is covered at the same benefit level as a supply. If the pharmaceutical is available in an oral dosage form, the Plan will not cover it in the form of an injectable medication unless it is medically necessary that the member use the injectable form. In addition, infusion and in-office injectables may require prior authorization by Moda Health or be subject to specific benefit limitations (more information is available on the Moda Health website). Prescription Medication benefit is in section 7.12.

7.11.2 Oral Anti-cancer Medication

A prescribed, orally-administered anticancer medication that is given in the professional provider's office is covered at the same benefit level as a supply. In addition, oral anti-cancer medication may require prior authorization by Moda Health or be subject to specific benefit limitations (more information is available on the Moda Health website). Pharmacy benefits are in section 7.12.

7.12 PHARMACY PRESCRIPTION MEDICATION BENEFIT

7.12.1 Definitions

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

Brand Substitution. Both generic and brand medications are covered. If a member requests, or the treating professional prescribes, a brand medication when a generic equivalent is available, the member will be responsible for the brand copayment or coinsurance plus the difference in cost between the generic and brand medication. As the difference in cost between the generic and the brand medication is not a covered expense, the member will at all times be responsible for payment of this difference. The difference in cost between the generic and brand medication does not apply towards the member's plan year out of pocket maximum.

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

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

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

Non Preferred Brand Medications that are not designated as preferred have been reviewed by Moda Health and do not have significant therapeutic advantage over their preferred alternative(s). These products are usually not recommended as first line therapy and different methods of treatment exist.

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

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

Note: The preferred medication list and the tiering of medications are subject to change and will be periodically updated. Members with any questions regarding coverage should contact Customer Service.

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

Preferred Tier Drugs including specialty preferred medications, have been reviewed by Moda Health and found to be clinically effective at a favorable cost when compared to other

medications in the same therapeutic class and/or category. Generic medications that have been identified as having no more favorable outcomes from a clinical perspective than other more cost effective may be included in this tier.

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

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

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

7.12.2 Covered Expenses

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

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

7.12.3 Covered Medication Supply

A **covered medication supply** includes the following:

a. A legend medication that is medically necessary for the treatment of a medical condition
b. Compounded medications containing at least one covered medication as the main ingredient
c. Must be prescribed by an approved provider and dispensed from a licensed pharmacy employing licensed registered pharmacists
d. Selected over-the-counter (OTC) products (such as covered diabetic supplies and insulins), when accompanied with a valid prescription. The same benefit parameters such as cost sharing and day supply restrictions will apply to covered OTC products. Additional information related to covered OTC products is available on myModa or by contacting Customer Service
e. Select prescribed preventive medications required under the Affordable Care Act
f. Medications for treating tobacco dependence, including prescribed OTC nicotine patches, gum or lozenges from an in-network retail pharmacy available with no cost sharing as required under the Affordable Care Act.

g. Legend contraceptive medications and devices for birth control and medical conditions covered under the Plan
h. Select immunizations and related administration fees are covered with no cost sharing at in-network retail pharmacies (e.g. influenza, pneumonia and shingles vaccines). Covered immunizations are limited to those recommended by the Advisory Committee on Immunization Practices of the Center for Disease Control and Prevention. Immunizations for the sole purpose of travel or to prevent illness which may be caused by a work environment are not covered

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

7.12.4 Mail Order Pharmacy

Members have the option of obtaining prescriptions for covered medications through an exclusive mail order pharmacy. Prescriptions purchased through the mail order drug program are subject to the Moda Health brand substitution policy. A mail order pharmacy form can be obtained from myModa, or by contacting Customer Service.

7.12.5 Specialty Services And Pharmacy

The pharmacist and other professional providers will advise a member if a prescription requires prior authorization or delivery by an exclusive pharmacy. Specialty medications are often used to treat complex chronic health conditions. Because specialty treatments often require special handling techniques, careful administration and a unique ordering process, the Plan provides enhanced member services for these medications. Information about the clinical services and a list of eligible specialty medications are available on myModa or by contacting Pharmacy Customer Service at 503-265-2911 or toll free at 866-923-0411. If a member does not purchase these medications at the exclusive specialty pharmacy provider, the medication expense will not be covered.

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

7.12.5.2 Step Therapy

Step therapy requires members to try selected medications before proceeding to alternative treatments. Brand medications are available as shown in section 7.12.3 once members have tried and failed first line therapies.

7.12.6 Limitations

To ensure appropriate access to drugs the following limitations will apply.

a. In addition to those medications included in the current prior authorization list on myModa, prior authorization is required for
    i. Retail prescriptions with a net cost over $1,000 for a 31 day
    ii. Mail-order and specialty prescriptions with a net cost over $3,000
    iii. Compounded medications with a net cost over $150, or a quantity greater than the retail day allowance
b. New FDA approved medications are subject to review and may be subject to additional coverage parameters, requirements, or limits established by the Plan
c. If a brand medication is dispensed when a generic equivalent is available, the member will be responsible for the difference in cost between the generic and brand medication. Expenses incurred due to brand substitution do not accrue to the out-of-pocket maximum
d. Select specialty medications that have been determined to have a high discontinuation rate or short durations of use may be limited to a 15 day supply
e. Claims for medications purchased outside of the United States and its territories will only be covered in emergency and urgent care situations
f. Early refill of medications for travel outside of the United States is subject to review. When allowed, is limited to once every 6 months
g. Specialty medications with dosing intervals beyond 31 days will be assessed an increased copayment consistent with the day supply

7.12.7 Exclusions

The following services, procedures and conditions are not covered by the Plan, even if otherwise medically necessary or if recommended, referred, or provided by a professional provider, pharmacist or pharmacy. In addition, any direct complication or consequence that arises from these exclusions will not be covered, except for emergency medical conditions. See SECTION 8 for additional exclusions that may apply.

a. **Charges Over the Maximum Plan Allowance**
b. **Cosmetic.** Medications, including hormones, prescribed or used for cosmetic purposes
c. **Devices.** Including, but not limited to therapeutic devices and appliances. Information for contraceptive devices is in section 7.12.3
d. **Experimental or Investigational Medications.** Including any medication used for an experimental or investigational purpose, even if it is otherwise approved by the federal government or recognized as neither experimental nor investigative for other uses or health conditions
e. **Foreign Medication Claims.** Medications purchased from non-U.S. mail order or online pharmacies or U.S. mail or online pharmacies acting as agents of non-U.S. pharmacies
f. **Hair Growth Medications**
g. **Immunization Agents for Travel**
h. **Infertility Medications**
i. **Institutional Medications.** To be taken by or administered to a member in whole or in part while the member is a patient in a hospital, a sanitarium, a rest home, a skilled nursing facility, an extended care facility, a nursing home, or a similar institution

j. **Medication Administration.** A charge for administration or injection of a medication except for select medications at in-network retail pharmacies
k. **Medications Covered Under Another Benefit.** Such as medications covered under home health, medical, etc
l. **Medications Prescribed by a Relative.** Prescriptions written or ordered by members or their relatives, including a spouse, domestic partner, child, sibling, or parent of a member or his or her spouse or domestic partner
m. **Non-Covered Condition.** A medication prescribed for purposes other than to treat a covered medical condition
n. **Nutritional Supplements and Medical Foods**
o. **Off-label Use.** Medications prescribed for or used for non-FDA approved indications, unless approved by the Health Resources Commission
p. **Over the Counter (OTC) Medications** and prescription medications for which there is an OTC equivalent or alternative
q. **Repackaged Medications**
r. **Replacement Medications and/or Supplies**
s. **Sexual Disorders.** Except gender identity medications or devices prescribed or used to treat sexual dysfunction
t. **Treatment Not Medically Necessary.** Including medications that are:
    i. Prescribed for purposes other than treating disease
    ii. Either inappropriate or inconsistent with the symptoms or diagnosis of a member's condition
    iii. Not representative of the standard treatment by the medical community in the service area in which they are received
    iv. Primarily rendered for the convenience of a member or a provider
    v. Not a cost-effective option when considering common alternatives that can be safely provided to a member
u. **Untimely Dispensing.** Drugs or medicines that are dispensed more than one year after the order of a professional provider
v. **Vitamins and Minerals.** Over-the-counter (OTC) vitamins and minerals, except those required by the U.S. Preventive Services Task Force
w. **Weight Loss Medications.**

SECTION 8 GENERAL EXCLUSIONS

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

Benefits Not Stated
Services and supplies not specifically described in this handbook as covered expenses.

Birthing Classes

Charges Over the Maximum Plan Allowance
Except when required under the Plan's coordination of benefits rules (see section 12.1).

Comfort and First-Aid Supplies
Including, but not limited to footbaths, vaporizers, electric back massagers, footpads, heel cups, shoe inserts, band-aids, cotton balls, cotton swabs, and off-the-shelf wrist, ankle or knee braces.

Cosmetic Procedures
Any procedure requested for the purpose of improving or changing appearance without restoring impaired body function, including hormone treatment, rhinoplasty, breast augmentation, lipectomy, liposuction, and hair removal (including electrolysis and laser). Exceptions are provided for reconstructive surgery:

a. following a mastectomy (section 7.8.7)
b. as part of gender identity services (section 7.8.9)
c. and complications of reconstructive surgeries if medically necessary and not specifically excluded

Court-Ordered Services
Those related to unlawful behavior by the member, including a sex offender treatment program. This exclusion does not apply to medically necessary services

a. provided pursuant to civil commitment proceedings for mental illness
b. for members age 17 or younger
c. provided pursuant to Driving Under the Influence of Intoxicants

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

Dental Examinations and Treatment; Orthodontia
Except as specifically provided for in section 7.8.12 and 7.8.13, dental examination and treatment and if medically necessary to restore function due to craniofacial anomaly.

Enrichment Programs
Psychological or lifestyle enrichment programs including self-help programs, educational programs, assertiveness training, marathon group therapy, and sensitivity training.

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

Faith Healing

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

Financial Counseling Services

Food Services
"Meals on Wheels" and similar programs.

Guest Meals in a Hospital or Skilled Nursing Facility

Hearing Aids
Except as specifically provided for in section 7.9.9.

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

Homemaker or Housekeeping Services

Illegal Acts, Riot or Rebellion
Services and supplies for treatment of an medical condition caused by or arising out of a member's voluntary participation in a riot, armed invasion or aggression, insurrection or rebellion or arising directly from an illegal act.

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

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

Intellectual Disability/Learning Disorders
Treatment related to intellectual disability for members age 18 or older and custodial services or supplies provided by an institution for the intellectually disabled. Treatment for learning disorders.

Legal Counseling

Massage or Massage Therapy

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

Missed Appointments

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

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

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

Nutritional Counseling
Except as provided for in section 7.

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

a. Gastric restrictive procedures with or without gastric bypass (except as provided in section 7.10.1), or the revision of such procedures
b. Weight management services such as weight loss programs, exercise programs, counseling, hypnosis, biofeedback, neurolinguistic programming, guided imagery, relaxation training and subliminal suggestion used to modify eating behaviors
c. Any medication or formula related to or resulting from the treatment of weight loss or obesity even if prescribed by a provider

The Plan will cover services and supplies that are necessary for the treatment of established medical conditions that may be caused by or made worse by obesity, but services and supplies that do so by treating the obesity directly are not covered, except as required under the Affordable Care Act and as provided in section 7.10.1.

Orthopedic Shoes
Except as provided for in section 7.9.8.

Orthognathic Surgery
Including associated services and supplies.

Pastoral and Spiritual Counseling

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

Physical Exercise Programs

Private Nursing Services

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

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

Reports and Records
Including charges for the completion of claim forms.

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

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

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

Service Related Conditions
Treatment of any condition caused by or arising out of a member's service in the armed forces of any country or as a military contractor or from an insurrection or war.

Services Otherwise Available
Including those services or supplies:

a. for which payment could be obtained in whole or in part if a member had applied for payment under any city, county, state or federal law, except for Medicaid coverage
b. for which a member cannot be held liable because of an agreement between the provider and another third-party payer which has paid or is obligated to pay for such service or supply
c. or which no charge is made, or for which no charge is normally made in the absence of insurance
d. provided under separate contracts that are used to provide coordinated coverage for covered persons in a group and are considered parts of the same plan
e. a member could have received in a hospital or program operated by a government agency or authority. This exclusion does not apply to:
    i. covered services provided at any hospital owned or operated by the state of Oregon or any state-approved community mental health and developmental disabilities program
    ii. veterans of the armed forces, in which case covered services and supplies furnished by the Veterans' Administration of the United States that are not service-related are eligible for payment according to the terms of the Plan

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

Services Provided By Volunteer Workers

Sexual Dysfunctions and Paraphilias
The Plan covers services delivered by mental health providers for the treatment of sexual dysfunction diagnoses listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders, but does not cover services or supplies delivered by other medical providers for sexual dysfunction except for gender identity disorder. The Plan does not cover services for paraphilias.

Support Education
Including:

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

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

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

Taxes

Telemedical Health Services
Including telephone visits or consultations and telephone psychotherapy, except as specifically provided for in section 7.8.18.

Telephones and Televisions in a Hospital or Skilled Nursing Facility

Therapies
Services or supplies related to intellectual disability for members age 18 or older, or related to learning disorders, hippotherapy, and maintenance therapy and programs.

Third-party Liability Claims
Services and supplies for treatment of a medical condition for which a third party is or may be responsible, to the extent of any recovery received from or on behalf of the third party (see section 11.3.2).

Transportation
Except medically necessary ambulance transport.

Treatment After Coverage Terminates
The only exception is if a member is hospitalized at the time the Plan terminates (see section 7.2), or for covered hearing aids ordered before coverage terminates and received within 90 days of the end date.

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

Treatment Not Medically Necessary
Including services or supplies that:

a. Are not medically necessary for the treatment or diagnosis of a condition otherwise covered under the Plan
b. Are either inappropriate or inconsistent with the symptoms or diagnosis of a member's condition
c. Are not established as the standard treatment by the medical community in the service area in which they are received
d. Are primarily rendered for the convenience of a member or a provider
e. Are not the least costly of the alternative supplies or levels of service that can be safely provided to a member. For example, coverage is not allowed for an inpatient hospital stay or residential chemical dependency treatment program when an appropriate level of treatment could be delivered in an outpatient setting such as an ambulatory surgery facility or outpatient chemical dependency treatment program

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

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

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

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

Wigs, Toupees, Hair Transplants

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

SECTION 9 ELIGIBILITY

The Plan's eligibility rules are outlined in the Oregon Administrative Rules under OAR 111-015-0001. The date a person becomes eligible may be different than the date coverage begins. More specific information can be found in section 10.

9.1 ELIGIBILITY AUDIT

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

SECTION 10 ENROLLMENT

10.1 NEWLY-HIRED AND NEWLY-ELIGIBLE ACTIVE ELIGIBLE EMPLOYEES

The Plan's enrollment rules for newly-hired and newly-eligible active eligible employees are outlined in the Oregon Administrative Rules under OAR 111-040-0010.

10.2 QUALIFIED STATUS CHANGES

The Plan's enrollment rules for qualified status changes are outlined in the Oregon Administrative Rules under OAR 111-040-0040.

An eligible employee and their spouse, registered domestic partner, and/or children may also have additional enrollment rights under the Children's Health Insurance Program Reauthorization Act of 2009 if prior coverage was under Medicaid or a children's health insurance program (CHIP) and such coverage was terminated due to loss of eligibility. Special enrollment must be requested within 60 days of the termination.

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

The special enrollment rights as described above apply:

a. To an eligible employee who loses other coverage or becomes eligible for a premium assistance subsidy
b. To a spouse, domestic partner, or child who loses coverage under the other plan or becomes eligible for a premium assistance subsidy
c. To both if neither is enrolled in the Plan, and either loses coverage under the other plan or becomes eligible for a premium assistance subsidy

To enroll, an eligible employee must submit a complete and signed application within the required timeframe, along with a certificate of creditable coverage from the previous plan.

Note: A new dependent may cause a premium increase. Premiums will be adjusted accordingly. Such adjustments will apply during the first 60 days of coverage for newborn or adopted children. If payment is required but not received, the child will not be covered. A signed copy of court-ordered guardianship will be required for coverage of a grandchild.

10.3 Effective Dates

The Plan's effective dates for enrollment are outlined in the Oregon Administrative Rules under OAR 111-040-0001.

10.4 Open Enrollment

The Plan's open enrollment rules are outlined in the Oregon Administrative Rules under OAR 111-040-0020.

10.5 Late Enrollment

The Plan's late enrollment rules are outlined in the Oregon Administrative Rules under OAR 111-040-0030.

10.6 Returning To Active Eligible Employee Status

The Plan's enrollment rules for those persons returning to active eligible employee status are outlined in the Oregon Administrative Rules under OAR 111-040-0035.

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

10.7 Removing An Ineligible Individual From Benefit Plans

The Plan's rules for removing an ineligible person from the Plan are outlined in the Oregon Administrative Rules under OAR 111-040-0015.

10.8 When Coverage Ends

Termination dates for loss of eligibility, death of the active eligible employee, and retirement of the active eligible employee are outlined in the Oregon Administrative Rules under OAR 111-040-0005. When the subscriber's coverage ends, coverage for all enrolled dependents also ends. In addition, there are a variety of other circumstances in which a member's coverage will end. These are described in the following paragraphs.

10.8.1 Group Plan Termination

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

Moda Health may terminate the group policy for fraud or intentional misrepresentation of material fact by OEBB, or for OEBB's noncompliance with material policy provisions.

In the event the group policy is terminated for a reason other than nonpayment of premiums and OEBB does not replace the insurance coverage, Moda Health will mail a notice of termination to OEBB. Group Plan termination includes termination of a multiple-employer trust policy. Moda Health's notice will be mailed within 10 working days of the date of termination. The notice will explain members' rights under federal and state law regarding and continuation of coverage. It is the responsibility of OEBB to send the information contained in the notice to members.

If Moda Health does not give notice as required by this provision, the group policy shall remain in full force from the date notice should have been provided until the date the notice is received by OEBB, and Moda Health will waive the premiums owing for this period. In this case, the period during which members have to apply for continuation coverage will begin on the date OEBB receives the notice.

10.8.2 Termination By A Subscriber

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

10.8.3 Rescission By Insurer

The Plan's enrollment rules for rescission by insurer are outlined in OEBB's Administrative Rules. Members may also refer to the OEBB Member Benefits Guide for additional information on rescinding.

10.8.4 Other

Information is in Continuation of Health Coverage (section 14).

10.9 DECLINATION OF COVERAGE

The Plan's rules for declining coverage are outlined in the Oregon Administrative Rules under OAR 111-040-0050.

SECTION 11 CLAIMS ADMINISTRATION & PAYMENT

11.1 SUBMISSION AND PAYMENT OF CLAIMS

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

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

11.1.1 Hospital and Professional Provider Claims

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

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

When a member is billed by the hospital or professional provider directly, he or she should send a copy of the bill to Moda Health at the address listed below,

Moda Health
Attn: Medical
P.O. Box 40384
Portland, Oregon 97240

and include all of the following information:

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

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

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

11.1.2 Ambulance Claims

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

11.1.3 Tobacco Cessation Program Claims

Moda Health will be billed directly by the exclusive tobacco cessation program for the cost of counseling, consultation and supplies. Other providers may require a member to pay the charges and submit the claim to Moda Health. If this happens, the member submit a claim for reimbursement using the claim form specific to the tobacco cessation program. This form is available on myModa or by contacting Customer Service.

11.1.4 Prescription Medication Claims

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

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

11.1.5 Explanation of Benefits (EOB)

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

If a member does not receive an EOB or an e-mail indicating that an EOB is available within a few weeks of the date of service, this may indicate that Moda Health has not received the claim. To be eligible for reimbursement, claims must be received within the claim submission period explained in section 11.1.

11.1.6 Claim Inquiries

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

11.2 DISPUTE RESOLUTION

11.2.1 Definitions

For purposes of section 11.2, the following definitions apply:

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

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

Authorized Representative means an individual who by law or by the consent of a person may act on behalf of the person.

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

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

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

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

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

11.2.2 Time Limit for Submitting Appeals

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

11.2.3 The Review Process

The Plan has a 2-level internal review process consisting of a first-level appeal and a second-level appeal. If a member is not satisfied with the outcome of the second-level appeal, and the dispute meets the specifications outlined in section 11.2.6, the member may request external review by an independent review organization. The first and second levels of appeal must be exhausted to proceed to external review, unless Moda Health agrees otherwise.

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

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

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

11.2.4 First-level Appeals

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

Appeals related to an urgent care claim will be entitled to expedited review upon request. Expedited reviews will be completed within 72 hours in total for the first and second level appeals combined after receipt of those appeals by Moda Health, not counting the lapse between the first-level appeal determination and receipt of the second-level appeal by Moda

health. If the member fails to provide sufficient information for Moda Health to make a decision at each appeal level, Moda Health will notify the member within 24 hours of receipt of the appeal of the specific information necessary to make a decision. The member must provide the specified information as soon as possible.

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

11.2.5 Second-level Appeals

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

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

11.2.6 External Review

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

a. The dispute must relate to an adverse determination based on a utilization review decision or whether a course or plan of treatment that a member is undergoing is an active course of treatment for purposes of continuity of care (see section 6.6); or cases in which Moda Health fails to meet the internal timeline for review or to the federal requirements for providing related information and notices
b. The request for external review must be in writing no more than 180 days after receipt of the final internal adverse benefit determination. A member may submit additional information to the independent review organization within 5 days, or 24 hours for an expedited review.
c. The member must sign a waiver granting the independent review organization access to his or her medical records
d. The member must have exhausted the appeal process described in sections 11.2.4 and 11.2.5. However, Moda Health may waive this requirement and have a dispute referred directly to external review with the member's consent. For an urgent care claim or when

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

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

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

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

11.2.7 Complaints

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

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

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

11.2.8 Additional Member Rights

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

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

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

11.3 BENEFITS AVAILABLE FROM OTHER SOURCES

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

11.3.1 Coordination Of Benefits (COB)

This provision applies when a member has healthcare coverage under more than one plan. A complete explanation of COB is in SECTION 12.

11.3.2 Third-Party Liability

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

The member agrees that Moda Health has the rights described in section 11.3.2. Moda Health may seek recovery under one or more of the procedures outlined in this section. The member agrees to do whatever is necessary to fully secure and protect, and to do nothing to prejudice, Moda Health' right of recovery or subrogation as discussed in this section. Moda Health has discretion to interpret and construe these recovery and subrogation provisions.

11.3.2.1 Definitions

For purposes of section 11.3.2, the following definitions apply:

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

Recovery Funds means any amount recovered from a third party.

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

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

11.3.2.2 Subrogation

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

11.3.2.3 Right of Recovery

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

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

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

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

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

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

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

11.3.2.4 Additional Provisions

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

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

    i. Signing and delivering any documents Moda Health reasonably requires to protect its rights, including a Third Party Reimbursement Questionnaire and Agreement. If the member has retained an attorney, then the attorney must also sign the agreement. The Plan will not be required to pay benefits until the agreement is properly signed and returned
    ii. Providing any information to Moda Health relevant to the application of the provisions of section 11.3.2, including all information available to the member, or any representative or attorney representing the member, relating to the potential third-party claim. This may include medical information, settlement correspondence, copies of pleadings or demands, and settlement agreements, releases or judgments
    iii. Notifying Moda Health of the potential third-party claim for which the Plan may issue benefits. The member has this responsibility even if the first request for payment of benefits is a bill or invoice submitted to Moda Health by the member's provider
    iv. Taking such actions as Moda Health may reasonably request to assist it in enforcing its third-party recovery rights

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

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

d. The member agrees that Moda Health may notify any third party, or third party's representatives or insurers, of its recovery rights described in section 11.3.2

e. Even without the member's written authorization, Moda Health may release to, or obtain from, any other insurer, organization or person, any information it needs to carry out the provisions of section 11.3.2

f. Section 11.3.2 applies to any member for whom advance payment of benefits is made by Moda Health whether or not the event giving rise to the member's injuries occurred before the member became covered by Moda Health

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

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

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

11.4 MEDICARE

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

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

Members with end-stage renal disease (ESRD) should enroll in Medicare as soon as they are eligible to do so.

SECTION 12 COORDINATION OF BENEFITS

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

12.1 DEFINITIONS

For purposes of SECTION 12, the following definitions apply:

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

Plan includes:

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

Plan does not include:

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

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

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

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

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

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

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

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

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

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

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

12.2 HOW COB WORKS

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

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

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

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

a. If this Plan is primary, it will provide its benefits first
b. If this Plan is secondary and the non-complying plan does not provide its primary payment information within a reasonable time after it is requested to do so, this Plan will assume that the benefits of the non-complying plan are identical to this Plan’s benefits. This Plan will provide its benefits first, but the amount of the benefits payable shall be determined as if this Plan were the secondary plan
c. If the non-complying plan reduces its benefits so that the member receives less in benefits than he or she would have received had this Plan provided its benefits as the secondary plan and the non-complying plan provided its benefits as the primary plan, then this Plan shall advance additional benefits equal to the difference between the

amount that was actually paid and the amount that should have been paid if the non-complying plan had not improperly reduced its benefits. Additional payment will be limited so that this Plan will not pay any more than it would have paid if it had been the primary plan. In consideration of such an advance, this Plan shall be subrogated to all rights of the member against the non-complying plan

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

The first of the following rules that applies will govern:

a. **Non-dependent/Dependent.** If a plan covers the member as other than a dependent, for example, an employee, member of an organization, primary insured, or retiree, then that plan will determine its benefits before a plan that covers the member as a dependent. However, if the member is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the member as a dependent and primary to the plan covering the member as other than a dependent (e.g. a retired employee), then the order of benefits between the two plans is reversed
b. **Dependent Child/Parents Married or Living Together.** If the member is a dependent child whose parents are married or are living together whether or not they have ever been married or registered domestic partners, the plan of the parent whose birthday falls earlier in the calendar year is the primary plan. If both parents' birthdays are on the same day, the plan that has covered the parent the longest is the primary plan. (This is called the 'Birthday Rule')
c. **Dependent Child/Parents Separated or Divorced or Not Living Together.** If the member is a dependent child of divorced or separated parents, or parents not living together whether or not they have ever been married or domestic partners, then the following rules apply:
    i. If a court decree states that one of the parents is responsible for the healthcare expenses of the child, and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to plan years commencing after the plan is given notice of the court decree
    ii. If a court decree states that both parents are responsible for the healthcare expenses of the child, or that the parents have joint custody without specifying that one parent is responsible, the 'birthday rule' described above applies
    iii. If there is not a court decree allocating responsibility for the child's healthcare expenses, the order of benefits is as follows: The plan covering the
        A. Custodial parent
        B. Spouse or domestic partner of the custodial parent
        C. Non-custodial parent
        D. Spouse or domestic partner of the non-custodial parent

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

12.4 EFFECT ON THE BENEFITS OF THIS PLAN

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

If the primary plan is a closed panel plan and the member uses an out-of-network provider, the secondary plan shall provide benefits as if it were the primary plan, except for emergency services or authorized referrals that are paid or provided by the primary plan.

12.4.1 Pharmacy COB

Claims subject to the COB provision of the Plan may be submitted electronically by pharmacies or through the direct member reimbursement paper claim process. The preferred method is for

the pharmacy to electronically transmit the primary plan's remaining balance to Moda Health for processing. If approved, the secondary claim will be automatically processed according to plan benefits. Members who are unable to have their secondary claims processed electronically may submit a claim reimbursement request directly to Moda Health (see section 11.1.4).

The manner in which a pharmacy claim is paid by the primary payer will affect how Moda Health pays for the claim as the secondary plan. In-network pharmacies are prohibited from coordinating with manufacturer-sponsored discount programs for brand medications with available generic or over-the-counter options.

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

Approved by Primary:

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

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

SECTION 13 MISCELLANEOUS PROVISIONS

13.1 RIGHT TO COLLECT AND RELEASE NEEDED INFORMATION

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

13.2 CONFIDENTIALITY OF MEMBER INFORMATION

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

13.3 TRANSFER OF BENEFITS

Only members are entitled to benefits under the Plan. These benefits are not assignable or transferable to anyone else. Any attempted assignment or transfer will not be binding on Moda Health, except that Moda Health shall pay amounts due under the Plan directly to a provider upon a member's written request.

13.4 RECOVERY OF BENEFITS PAID BY MISTAKE

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

13.5 CORRECTION OF PAYMENT

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.

13.6 CONTRACT PROVISIONS

OEBB's policy with Moda Health 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.

13.7 REPLACING ANOTHER PLAN

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

13.8 RESPONSIBILITY FOR QUALITY OF MEDICAL CARE

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

13.9 WARRANTIES

All statements made by OEBB, 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 OEBB or the member, a copy of which has been given to OEBB or member or the member's beneficiary.

13.10 GUARANTEED RENEWABILITY

Moda Health is required to renew coverage at the option of OEBB. Coverage may only be discontinued or non-renewed:

a. For nonpayment of the required premiums by OEBB
b. For fraud or intentional material misrepresentation of OEBB, or with respect to coverage of individual members, the members or their representatives
c. When the number or percentage of members is less than required by participation requirements
d. For non-compliance with the employer contribution requirements in the policy
e. When Moda Health discontinues offering and/or renewing, all of its group health benefit plans in Oregon or in a specified service area within Oregon. In order to discontinue plans under this provision, Moda Health:
    i. Must give notice of the decision to the Director of the Department of Consumer and Business Services and to all groups, associations, trusts, and discretionary groups covered by the plans
    ii. May not cancel coverage under the plans for 180 days after the date of the notice required immediately above if coverage is discontinued in the entire state or, except as provided in the next subsection of this paragraph, in a specified service area
    iii. May not cancel coverage under the plans for 90 days after the date of the notice required under the first subparagraph of this paragraph if coverage is discontinued in a specified service area because of an inability to reach an agreement with the healthcare providers or organization of healthcare providers to provide services under the plans within the service area
    iv. Must discontinue offering or renewing, or offering and renewing, all health benefit plans issued by Moda Health in the group market in Oregon or in the specified service area
f. When Moda Health discontinues offering and renewing a group health benefit plan in a specified service area within Oregon because of an inability to reach an agreement with the healthcare providers or organization of healthcare providers to provide services under the plan within the service area. In order to discontinue a plan under this provision, Moda Health:
    i. Must give notice of the decision to the director and to all groups, associations, trusts, and discretionary groups, covered by the plan
    ii. May not cancel coverage under the plan for 90 days after the date of the notice required immediately above
    iii. Must offer in writing to each group, association, trust, and discretionary group, covered by the plan, all other group health benefit plans that Moda Health offers in the specified service area. Moda Health shall offer the plans at least 90 days prior to discontinuation

g. When Moda Health discontinues offering and/or renewing a health benefit plan for all groups, associations, trusts, and discretionary groups in Oregon or in a specified service area within Oregon, other than a plan discontinued under the paragraph immediately above. With respect to plans that are being discontinued, Moda Health must:
    i. Offer in writing to each group, association, trust, and discretionary group covered by the plan, one or more health benefit plans that Moda Health offers in the specified service area
    ii. Offer the plans at least 180 days prior to discontinuation
    iii. Act uniformly without regard to the claims experience of the affected groups, associations, trusts, and discretionary groups of the health status of any current or prospective members
h. When the director orders Moda Health to discontinue coverage in accordance with procedures specified or approved by the director upon finding that the continuation of the coverage would:
    i. not be in the best interest of the members
    ii. impair Moda Health's ability to meet contractual obligations
i. When, in the case of a group health benefit plan that delivers covered services through a specified network of healthcare providers, there is no longer any member who lives, resides or works in the service area of the provider network
j. When, in the case of a health benefit plan that is offered in the group market only through one or more bona fide associations, the membership of an employer in the association ceases and the termination of coverage is not related to the health status of any member
k. For misuse of a provider network provision. As used in this paragraph, 'misuse of a provider network provision' means a disruptive, unruly or abusive action taken by a member that threatens the physical health or well-being of healthcare staff and seriously impairs Moda Health's ability or its in-network providers to provide services to the member. The member under this paragraph retains the rights as described under ORS 743.804

13.11 NO WAIVER

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

13.12 GROUP IS THE AGENT

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

13.13 Compliance with Federal and State Mandates

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

13.14 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. Should federal law, including but not limited to the Affordable Care Act of 2010, supersede state law and create a discrepancy between state and federal law, federal law shall govern.

13.15 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.

13.16 Time Limits For Filing A Lawsuit

Any legal action arising out of, or related to, the Plan and filed against Moda Health by a member or any third party, must be filed in court no more than 3 years after the time the claim was filed (see section 11.1). All internal levels of appeal under the Plan must be exhausted before filing a legal action in court.

13.17 Evaluation Of New Technology

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

SECTION 14 CONTINUATION OF HEALTH COVERAGE

The Plan's continuation of coverage rules are outlined in the Oregon Administrative Rules under OAR 111-050-0001 through OAR 111-050-0080. Additional guidance on how to obtain continuation of coverage is outlined in the following sections.

14.1 FAMILY AND MEDICAL LEAVE

If the participating organization grants a leave of absence under the Family and Medical Leave Act of 1993, as amended (FMLA), the following rules will apply:

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

14.2 LEAVE OF ABSENCE

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

If granted a leave of absence by the participating organization, a subscriber may continue coverage based on OAR 111-050-0070. Premiums must be paid through OEBB in order to maintain coverage during a leave of absence.

14.3 Strike Or Lockout

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

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

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

14.4 Retirees

The Plan's continuation rules for retirees are outlined in the Oregon Administrative Rules under OAR 111-050-0010 through 111-050-0050.

14.5 Oregon Continuation For Spouses & Domestic Partners Age 55 And Over

14.5.1 Introduction

Moda Health will provide 55+ Oregon Continuation coverage to those members who elect it. Other than the inclusion of domestic partners, Moda Health will offer no greater rights than ORS 743.600 to 743.602 requires

14.5.2 Eligibility

a. If a spouse or domestic partner is 55 or older at the time coverage is lost due to death of the subscriber, divorce or legal separation, or termination of a domestic partnership, he or she may elect to continue coverage. The spouse or domestic partner cannot be eligible for Medicare

14.5.3 Notice And Election Requirements

OEBB is responsible for providing the required election notice to a spouse or domestic partner eligible under this section. If OEBB fails to provide notices as required under statute, premiums will be waived from the date the notice was required until the date notice is received by the spouse or domestic partner. OEBB will be responsible for such premiums.

OEBB will send an election notice within 14 days of receiving notice of an election event. The eligible spouse or domestic partner must return the election form within 60 days from the date mailed, or will lose the right to elect continued coverage under this section.

An eligible spouse or domestic partner who wants to continue coverage, is responsible for providing written notice of the event to OEBB. The notice should include the event date and the eligible individual's mailing address. If notice is not submitted timely, the spouse or domestic partner will lose eligibility rights under this section.

Notice of Divorce, Dissolution, or Legal Separation. If coverage is lost due to one of these events, the spouse or domestic partner must provide notice within 60 days of the event.

Notice of Death. If coverage is lost due to the subscriber's death, the spouse or domestic partner must provide notice within 30 days of the death.

14.5.4 Premiums

The election notice will include information regarding the cost of continuation coverage and the premium due date. Premiums are limited to 102% of the premiums paid by a current subscriber.

14.5.5 When Coverage Ends

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

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

14.6 COBRA CONTINUATION COVERAGE

The Plan's general COBRA rules are outlined in the Oregon Administrative Rules under OAR 111-050-0001.

14.6.1 Introduction

Moda Health will provide COBRA continuation coverage to those members who have experienced a qualifying event and elect coverage under COBRA

For purposes of section 14.6, Plan Administrator means either OEBB or a third party administrator delegated by OEBB to handle COBRA administration

A qualified beneficiary is a person who is eligible for COBRA continuation coverage.

14.6.2 Qualifying Events

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

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

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

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

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

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

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

14.6.3 Other Coverage

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

14.6.4 Notice And Election Requirements

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

Election Notice. The COBRA administrator will notify qualified beneficiaries of their right to continuation coverage after the Plan Administrator receives a timely qualifying event notice.

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

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

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

14.6.5 Length Of Continuation Coverage

If coverage terminates due to the subscriber's employment termination or reduction in hours, COBRA continuation coverage lasts for 18 months.

Spouses, domestic partners and children who lose coverage for qualifying events other than the subscriber's loss of employment or reduction of hours, are eligible for 36 months of continued coverage.

14.6.6 Extending The Length Of COBRA Coverage

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

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

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

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

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

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

Second Qualifying Event. An extension of coverage will be available to spouses and children who are receiving COBRA coverage if a second qualifying event occurs during the 18 months (or, in the case of a disability extension, the 29 months) following the subscriber's termination of employment or reduction of hours. The maximum amount of COBRA coverage available when a second qualifying event occurs is 36 months from the date of the first qualifying event. Such second qualifying events may include the death of a subscriber, divorce or legal separation from the subscriber, or a child's ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the member to lose coverage under the Plan if the first qualifying event had not occurred. (This extension is not available under the Plan when a subscriber becomes entitled to Medicare after his or her termination of employment or reduction of hours.).

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

Note: Longer continuation coverage may be available under Oregon Law for a subscriber's spouse or domestic partner who has entered into a "Declaration of Domestic Partnership" that is recognized under Oregon law 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 14.5).

14.6.7 Newborn Or Adopted Child

If, during continuation coverage, a child is born to or placed for adoption with the subscriber, the child is considered an eligible member. The subscriber may elect continuation coverage for the child provided the child satisfies the otherwise applicable plan eligibility requirements (for example, age). The participating organization must be notified within 60 days of the birth or placement to obtain continuation coverage. If the participating organization is not notified in a timely fashion, the child will not be eligible for continuation coverage.

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

14.7 UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

Coverage will terminate if a subscriber is called to active duty by any of the armed forces of the United States of America. However, if a subscriber requests to continue coverage under USERRA, coverage can be continued for up to 24 months or the period of uniformed service leave, whichever is shortest, provided the subscriber pays any required contributions toward the cost of the coverage during the leave. If the leave is 30 days or less, the contribution rate will be the same as for active members. If the leave is longer than 30 days, the required contribution will not exceed 102% of the cost of coverage.

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

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

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

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

SECTION 15 PATIENT PROTECTION ACT

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

15.1 What are a member's rights and responsibilities?

Members have the right to:

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

Members have the responsibility to:

a. Read this handbook to make sure they understand the Plan. Members are advised to call Customer Service with any questions
b. Treat all providers and their staff with courtesy and respect
c. Provide all the information needed for their physician or provider to provide good healthcare

d. Participate in making decisions about their medical care and forming a treatment plan
e. Follow instructions for care they have agreed to with their physician or provider
f. Use urgent and emergency services appropriately
g. To the extent required by the Plan, seek medical services only from their medical home primary care provider
h. Obtain approval from their medical home primary care provider before going to a specialist
i. Present their medical identification card when seeking medical care
j. Notify providers of any other insurance policies that may provide coverage
k. Reimburse Moda Health from any third-party payments they may receive
l. Keep appointments and be on time. If this is not possible, members must call ahead to let the provider know they will be late or cannot keep their appointment
m. Seek regular health checkups and preventive services
n. Provide adequate information to the Plan to properly administer benefits and resolve any issues or concerns that may arise

Members may call Customer Service for questions about these rights and responsibilities.

15.2 The Plan requires a medical home primary care provider to coordinate all healthcare needs. How does a member know when he or she needs a referral?

Generally, a referral is needed for services by any provider other than the medical home primary care provider. Otherwise, benefits may be reduced or denied. When medically necessary, the medical home primary care provider will usually refer a member to an in-network provider.

There are exceptions to the referral requirement under a medical home primary care provider plan. Routine maternity care, routine women's exams, routine exams for men, routine colorectal cancer screening, emergency treatment, chiropractic, naturopathic and acupuncture services and mental illness and chemical dependency treatment do not require a referral. However, members must contact Moda Health Behavioral Health for prior authorization of mental health or chemical dependency services (see section 3.1).

15.3 What if a member has a medical emergency?

A member who believes he or she has a medical emergency should call 9-1-1 or seek care from the nearest appropriate provider, such as a physician's or provider's office or clinic, urgent care facility or emergency room.

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

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

15.5 Will a member be informed if the medical home primary care provider is no longer participating in the network?

If a member's medical home primary care provider ends his or her participation in the network, Moda Health will inform the member and provide instructions on how to change the medical home primary care provider.

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

A member can file an appeal by contacting Customer Service or by writing a letter to Moda Health (P.O. Box 40384, Portland, Oregon 97240). Complete information can be found in section 11.2.

A member may also contact the Oregon Insurance Division:

Phone:	503-947-7984 or toll-free 888-877-4894
Mail:	PO Box 14480 Salem, Oregon 97309-0405-1
Internet:	www.oregon.gov/DCBS/insurance/gethelp/Pages/fileacomplaint.aspx
Email:	cp.ins@state.or.us

15.7 What are the prior authorization and utilization review criteria?

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

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

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

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

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

Moda Health protects members' information in several ways:

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

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

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

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

601 SW Second Avenue
Portland, Oregon 97204
www.modahealth.com/oebb

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

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

15.11 What additional information is available upon request?

The following documents are available by calling Customer Service:

a. Moda Health's annual report on complaints and appeals
b. Moda Health's efforts to monitor and improve the quality of health services

c. Procedures for credentialing network providers and how to obtain the names, qualifications, and titles of the providers responsible for a member's care
d. Prior authorization and utilization review procedures

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

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

a. The results of all publicly available accreditation surveys
b. A summary of Moda Health's health promotion and disease prevention activities
c. An annual summary of appeals
d. An annual summary of utilization review policies
e. An annual summary of quality assessment activities
f. An annual summary of scope of network and accessibility of services

Contact:

Oregon Insurance Division
PO Box 14480
Salem, Oregon 97309-0405
503-947-7984 or toll-free 888-877-4894
cp.ins@state.or.us

15.13 What is provider risk sharing?

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

SECTION 16 VALUE ADDED PROGRAMS

Aside from the medical benefits covered in the Plan, members are eligible for several value added programs that are not subject to the terms of the Plan.

16.1 WEIGHT WATCHERS

Members can take advantage of the Weight Watcher program OEBB offers by:

a. attending traditional Weight Watchers meetings in the community. Members will receive vouchers for a 13-week session mailed to their home
b. attending 13-week At Work meetings in their workplace
c. participating in a 3-month online subscription for Weight Watchers online with interactive tools and resources

More information is available at http://www.oregon.gov/oha/OEBB/Forms/Weight-Watchers-Gateway.pdf

16.2 TOBACCO CESSATION PROGRAM

OEBB offers a tobacco cessation benefit through the Alere Quit-for-life program. Enrollment in the program is covered once per lifetime and a 10-week supply of nicotine replacement therapy (patches or gum) is covered in full.

More information is available at https://www.modahealth.com/pdfs/oebb/tobacco_cessation.pdf

16.3 HEALTHY FUTURES PROGRAM

Healthy Futures is a program designed to encourage OEBB members to learn their individual health risks and how to take action to reduce or eliminate risks whenever possible.

More information is available at http://www.oregon.gov/oha/OEBB/Pages/Healthy-Futures.aspx.

P.O. Box 40384
Portland, OR 97204

Member Inquiries
503-265-2909 or 866-923-0409
En Español: 503-433-6313
Llamado Gratis: 888-786-7461

www.modahealth.com