# 2024

## Oregon Group Medical Plan

Public Employees' Benefit Board
Coordinated Care Model Plan
Synergy Full-Time

Effective Date: January 1, 2024
Group Number: 10002802

Public Employees' Benefit Board

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

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## SECTION 1. WELCOME TO MODA HEALTH

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

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

If you have questions, call one of the numbers listed in Section 2 or use the tools and resources on your member website, Member Dashboard, at www.modahealth.com/pebb. You can use it 24 hours a day, 7 days a week to get your plan information whenever it's convenient.

The group may change or replace this handbook at any time without your agreement. You can find the most current handbook on your Member Dashboard. All plan provisions are governed by the Group's agreement with Moda Health. This handbook may not contain every plan provision.

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

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

# SECTION 2. MEMBER RESOURCES

## 2.1 CONTACT INFORMATION

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

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

- Find an in-network provider with Find Care
- Get medication cost estimates and benefit tiers using our Prescription Price Check tool and formulary
- See if a service or supply you need must be prior authorized first www.modahealth.com/medical/referrals

**Medical Health Navigator (Customer Service) Department**
844-776-1593
En Español 888-786-7461

**Behavioral Health Customer Service Department**
800-799-9391

**Disease Management and Health Coaching**
800-592-8283

**Virtual Care preferred vendor**
CirrusMD
modahealth.com/cirrusmd

**Pharmacy Customer Service Department**
844-776-1594

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

**Telecommunications Relay Service** for the hearing impaired
711

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

**Public Employee's Benefit Board (PEBB)**
503-373-1102

## 2.2 MEMBER ID CARD

After you enroll, we will send you ID (identification) cards that show your group and ID numbers, and your provider networks. Show your card each time you receive services, so your provider will

know you are a Moda Health member. If you lose your ID card, you can get a new one through your Member Dashboard or by calling Customer Service.

## 2.3 NETWORKS

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

**Medical network**
Synergy

**Pharmacy network**
ArrayRx Core Network

**Travel network**
Aetna PPO Network

**Out-of-Area Networks**
Dependent children who live in Alaska: First Health Network
Dependent children who live in Idaho: Synergy and First Health Network
For dependent children who live in other states: Aetna PPO Network

## 2.4 CARE COORDINATION

### 2.4.1 Care Coordination

Our care coordinators work directly with facilities and providers to facilitate prior authorization of scheduled procedures, inpatient stays, and follow-up care as needed during your urgent or emergent admissions. During the time you are receiving care or are hospitalized, care coordinators may refer you to a case management nurse if they require additional assistance and coordination for complex or catastrophic conditions.

The hospital will call Moda Health to provide notification of all urgent/emergent hospital admissions within 48 hours, or as soon as possible.

Additional information regarding care coordination services is available at Member Dashboard under Healthcare coordination.

### 2.4.2 Case Management

Case management is a voluntary service when you experience complex conditions or catastrophic events and need assistance from a case management registered nurse or behavioral health specialist. Case managers can help by working with you as patient advocates to:

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

To make a referral to case management, you may contact Moda Health Healthcare Services case management by phone at 503-948-5561 or toll-free at 800-592-8283, by e-mail at casemgmtrefer@modahealth.com, by fax at 503-243-5105, or online at Member Dashboard to submit a referral form (available at www.modahealth.com/pdfs/referral_form_case_mgt.pdf). You can self-refer to case management or be referred by a family member, caregiver, provider or facility staff. To make a referral, please provide the following information:

a. Your name and ID number (this can be found on your Moda Health ID card)
b. Contact name and number
c. Reason for the referral

Once we receive a referral, a case manager will evaluate your situation and contact you within 5 business days.

Additional information regarding case management services is available at your Member Dashboard under Healthcare coordination.

### 2.4.3 Disease Management & Health Coaching

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

The care programs include:

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

You can learn more about Moda Health's disease management care programs at your Member Dashboard, by calling 503-948-5561 or toll-free at 800-592-8283, or by e-mail at careprograms@modahealth.com.

### 2.4.4 Behavioral Health

Moda Behavioral Health provides specialty services for managing mental health and substance abuse disorder benefits. We can help you access effective care in the right place and contain costs. You also have access to Spring Health's suite of online, virtual, and in-person behavioral health services. Behavioral Health Customer Service can help you find in-network providers and understand your mental health and substance use disorder benefits.

### 2.4.5 Wellness Programs

In addition to the group health plan benefits, value-added wellness programs are available to you to promote health and wellness. You are encouraged to take part in the following wellness programs:

#### 2.4.5.1 WW (formerly known as Weight Watchers) Program

You can take advantage of PEBB's WW program in the format that works best for your lifestyle:

a. **Digital** – gives you access to an easy-to-use app that has the tools you need, including food and activity tracking, thousands of recipes, 24/7 Expert Chat with a WW Coach, and so much more.
b. **Digital + Workshops** - gives you access to WW's digital tools, and weekly WW Workshops in the community or WW Workshops in the workplace (where applicable).

For more information visit: https://www.oregon.gov/oha/PEBB/Pages/WW-Experience.aspx

#### 2.4.5.2 HealthyYou

This program is called HealthyYou (Powered by WebMD ONE). The HealthyYou portal helps the member set goals, tracks their progress, keeps them motivated and provides valuable information along the way. Participation in this program is at no cost. Members can learn more about the program here: HealthyYou by WebMD ONE - Login (webmdhealth.com)

#### 2.4.5.3 Health Risk Assessment

You have access to a digital wellness platform with your Health Risk Assessment. You may access your Health Risk Assessment via modahealth.com/pebb and look for the Health Risk Assessment on your homepage. You must complete your Health Risk Assessment as part of your Healthy Engagement Model (HEM) Program.

#### 2.4.5.4 CareNet

You may call the 24-hour CareNet nurse line at 800-501-5046 for help with medical issues ranging from home-care remedies to recommended emergency care.

#### 2.4.5.5 Virta Health

Virta Health is a virtual clinic for type 2 diabetes reversal and prevention. Members can eat their way to better health thanks to personalized food plans and support from medical providers, professional coaches, and digital health tools at no cost. Members who are eligible to participate in the program will receive an invite.

## 2.5 OTHER RESOURCES

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

Membership with Moda Health includes other advantages as well. You have access to services, programs and tools to support their physical, mental and emotional health. These resources are not part of the Plan, and they are not insurance. You can access these extras through your Member Dashboard.

## SECTION 3. SCHEDULE OF BENEFITS

Look through this section for a quick summary the Plan's benefits. You will find details of the actual benefits in the sections after this summary. You will need to know the conditions, limitations and exclusions of the Plan that are explained there. Prior authorization may be required for some services (see section 6.1). Important terms are explained in Section 12.

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

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

| | **In-Network Benefits** | **Out-of-Network Benefits** |
|---|---|---|
| **Medical:** | | |
| **Annual Medical Deductible per Member** | **$250** | **$500** |
| **Maximum Annual Medical Deductible per Family** | **$750** | **$1,500** |
| **Annual Medical Out-of-Pocket Maximum per Member** | **$1,500** | **$4,000** |
| **Annual Medical Out-of-Pocket Maximum per Family** | **$4,500** | **$12,000** |
| **Pharmacy:** | | |
| **Annual Pharmacy Deductible per Member** | **$50** | |
| **Maximum Annual Pharmacy Deductible per Family** | **$150** | |
| **Annual Pharmacy Out-of-Pocket Maximum per Member** | **$1,000** | |
| **Annual Pharmacy Out-of-Pocket Maximum per Family** | **$3,000** | |
| **Maximum Annual Cost Sharing per Member (Medical & pharmacy)** | **$6,850** | **N/A** |
| **Maximum Annual Cost Sharing per Family (Medical & pharmacy)** | **$13,700** | **N/A** |

| **Services** | **Amount You Pay** Deductible applies unless noted differently | | **Section in Handbook & Details** |
|---|---|---|---|
| | **In-network** | **Out-of-network** | |
| | | | |
| **Urgent & Emergency Care** | | | |
| Ambulance Transportation | $75 per trip | $75 per trip | Section 7.3.1 |
| Emergency Room Facility (includes ancillary services) | $150 per visit* | $150 per visit* In-network deductibles and maximum cost sharing apply. | Section 7.3 No copay if admitted to hospital from emergency room. All services subject to inpatient benefits.<br><br>Other ancillary services billed separately are subject to standard cost sharing per service |
| Urgent Care Office Visit | $25 per visit | $25 per visit | Section 7.3.5 |

| Services | Amount You Pay<br>Deductible applies<br>unless noted differently | | Section in Handbook & Details |
|---|---|---|---|
| | In-network | Out-of-network | |
| | | | |
| **Preventive Services** | | | |
| Preventive Healthcare | | | Section 7.4 |
| Services as required under the Affordable Care Act, including: | | | Section 7.4 |
| Colonoscopy | No cost sharing | 30% | Section 7.4.1<br>One per 10 years, age 45+.<br>Related charges included |
| Immunizations | No cost sharing | 30% | Section 7.4.3 |
| Mammogram | No cost sharing | 30% | Section 7.4.8<br>One per year, age 40+ |
| Pediatric Screening | No cost sharing | 30% | Section 7.4.4<br>Age and frequency limits may apply |
| Preventive Health Exams (by primary care provider only) | No cost sharing | 30% | Section 7.4.5<br>6 visits in first year of life<br>7 exams from age 1 to 4<br>One per year, age 5+ |
| Tobacco Cessation Treatment | | | Section 7.4.7 |
| Consultation | No cost sharing | Not covered | |
| Supplies | No cost sharing | 15% | Frequency limits may apply |
| Women's Exam & Pap Test | No cost sharing | 30% | Section 7.4.8<br>One per year |
| Other preventive services Including: | | | |
| Prostate Rectal Exam | No cost sharing | 30% | Section 7.4.6<br>One per year, age 50+ |
| Prostate Specific Antigen (PSA) Test | No cost sharing | 30% | Section 7.4.6<br>One per year, age 50+ |
| Screening X-ray & Lab | No cost sharing | 30% | Section 7.4.5 |
| | | | |
| **General Treatment Services** | | | |
| Acupuncture | $10 per visit* | 30%** | Section 7.5.1<br>12 visits per year |
| Anticancer Medication | | | Section 7.5.2 |
| Injectable Medications | $10 per visit | 30% | |
| Self-administered Generic and Brand medications | $10, no deductible | 30% | 30-day supply. Specialty medications must be from the exclusive pharmacy provider |
| Applied Behavior Analysis | $10 per service, no deductible | 30% | Section 7.5.3 |
| Bariatric Surgery Facility | $50 per day/$250 per admission | Not covered | Section 7.5.4 |

| Services | Amount You Pay<br>Deductible applies unless noted differently | | Section in Handbook & Details |
|---|---|---|---|
| | In-network | Out-of-network | |
| | | | |
| Biofeedback | $10 per visit | 30% | Section 7.5.5<br>10 visits lifetime maximum |
| Dental Injury | $10 per procedure | 30% | Section 7.5.9 |
| Diabetes Services | No cost sharing | 30% | Section 7.5.10<br>Diabetes self-management program covered once, following diagnosis |
| Diabetic Supplies and Insulin | No cost sharing | No cost sharing | Section 7.7.1<br>Covered under the pharmacy benefit |
| Insulin Pumps | 15% | 30% | Section 7.5.13<br>Covered as a Durable Medical Equipment (DME) supply if you do not get them from a pharmacy |
| Diagnostic Procedures, including x-ray and lab | No cost sharing | 30% | Section 7.5.11 |
| Advanced Imaging | $100 per service* | $100* per service, then 30% | Section 7.5.11<br>Copay does not apply to services related to cancer diagnosis and treatment |
| Disease Management for Pain | No cost sharing | 30% | Section 7.5.12 |
| Durable Medical Equipment (DME), Supplies & Appliances | 15% | 30% | Section 7.5.13 |
| Disposable Supplies (provided in a professional provider's office) | 15% | 30% | Section 7.5.13 |
| Hearing Aids and Related Services | 10%, no deductible** | 10%, no deductible** | Section 7.5.17<br>Once every 36 months |
| Hearing Exams | $10 per visit, no deductible* | 30%, no deductible** | Section 7.5.17<br>Once every year |
| Home Healthcare | $10 per visit | 30% | Section 7.5.18<br>180 visits per year |
| Hospice Care | | | Section 7.5.19 |
| Home Care | No cost sharing | No cost sharing | |
| Inpatient Care | No cost sharing | No cost sharing | |
| Respite Care | No cost sharing | No cost sharing | |
| Hospital Inpatient Care | $50 per day/$250 per admission | $500* per admission then 40% | Section 7.5.20 |
| Hospital Physician Visits | No cost sharing | 30% | Section 7.5.21 |

| Services | Amount You Pay<br>Deductible applies unless noted differently<br>In-network | <br><br>Out-of-network | Section in Handbook & Details |
|---|---|---|---|
| | | | |
| Sleep Studies | $100 per procedure* | $100*, then 30% | |
| Infusion Therapy (Home or Outpatient) | $10 per visit | 30% | Section 7.5.23<br>Some medications may be limited to certain providers or settings, or covered separately under the pharmacy benefit. |
| Kidney Dialysis | $10 per service | 30% | Section 7.5.24 |
| Massage Therapy | $10 per visit* | 30%** | Section 7.5.25<br>$1,000 annual maximum |
| Mental Health Services | | | Section 7.5.28 |
| Office Visits | $10 per service, no deductible | 30% | |
| Intensive Outpatient | | | |
| Other Outpatient Services | | | |
| Coordinated Specialty Programs | No cost sharing | 30% | |
| Inpatient | $50 per day/$250 per admission | $500 per admission then 40% | |
| Partial Hospitalization | $50 per day/$250 per admission | 40% | |
| Residential Treatment Program | | | |
| Nutritional Therapy | No cost sharing for first 2 visits, then $10 per visit, no deductible | 30% | Section 7.5.30<br>Prior authorization required after 5 visits |
| Observation Care | $50 per day/$250 per admission | $500* per admission then 40% | Section 7.5.20 |
| Office Visits to Primary Care Providers | $10 per visit (First 4 visits, no deductible) | 30% | Section 7.5.31<br>In-network benefit only applies to your assigned PCP 360 |
| Specialist Visits | $10 per visit | 30% | Section 7.5.31 |
| Office Visits to Naturopaths, Chiropractors, Massage Therapists and Acupuncturists | $10 per visit* | 30%** | Section 7.5.31 |
| Office Visits for Chronic Conditions | No cost sharing | 30% | Section 7.5.31<br>Chronic conditions: asthma, diabetes, heart conditions |

| Services | Amount You Pay<br>Deductible applies<br>unless noted differently | | Section in Handbook & Details |
|---|---|---|---|
| | In-network | Out-of-network | |
| | | | |
| Rehabilitation & Habilitation (Physical, occupational and speech therapy) | | | Section 7.5.34<br>Rehabilitation up to 60 outpatient sessions and 30 inpatient days per year. Up to 60 days for head or spinal cord injury, or for treatment of a stroke. Habilitation only covered for mental health conditions |
| Outpatient | $10 per visit | 30% | |
| Cardiac Rehabilitation | $10 per service | 30% | |
| Inpatient | $50 per day/$250 per admission | 40% | |
| Skilled Nursing Facility Care | $50 per day/$250 per admission | 40% | Section 7.5.35<br>180 days per year |
| Spinal Manipulation | $10 per visit* | 30%** | Section 7.5.36<br>20 visits per year |
| Substance Use Disorder Services | | | Section 7.5.37 |
| Detoxification (Detox) | No cost sharing | 40% | |
| Office Visits | No cost sharing | 30% | |
| Intensive Outpatient | | | |
| Other Outpatient Services | | | |
| Inpatient | No cost sharing | 40% | |
| Partial Hospitalization | | | |
| Residential Treatment Program | | | |
| Surgery Procedures | | | Section 7.5.38 |
| Outpatient Surgery Professional Charges | $10 per service | 30% | |
| Outpatient Surgery Facility | $10 per service | $100* per service, then 40% | |
| Inpatient | No cost sharing | 30% | |
| Temporomandibular Joint Syndrome | $10 per service | Not covered | Section 7.5.39<br>Related physical therapy limited to 20 visits per year |
| Therapeutic Injections | $10 per service | 30% | Section 7.5.40 |
| Allergy Shots, Serums | $10 per service | 30% | Section 7.5.40 |
| Therapeutic X-ray | $10 per service | 30% | Section 7.5.41 |

| Services | Amount You Pay<br>Deductible applies<br>unless noted differently | | Section in Handbook & Details |
|---|---|---|---|
| | In-network | Out-of-network | |
| | | | |
| Transplants | | | Section 7.5.42<br>Only covered at an approved Center of Excellence facility. |
| Facility charges | $50 per day/$250 per admission | N/A | |
| Professional charges | $10 per visit | N/A | |
| E-Visits | No cost sharing | Not covered | Section 7.5.15 |
| Virtual Visits | | | Section 7.5.44 |
| Through CirrusMD | No cost sharing | N/A | Log on via modahealth.com/cirrusmd |
| Other providers | No cost sharing | 30% | |
| | | | |
| **Additional Cost Tier** | | | |
| Bunionectomy | $100 per procedure* | $100 per procedure*, then 30% | Section 4.1<br>Does not include services related to cancer diagnosis or treatment for traumatic injury |
| Hammertoe surgery | $100 per procedure* | $100 per procedure*, then 30% | |
| Morton's neuroma | $100 per procedure* | $100 per procedure*, then 30% | |
| Spinal injections for pain | $100 per procedure* | $100 per procedure*, then 30% | |
| Upper gastrointestinal endoscopy | $100 per procedure* | $100 per procedure*, then 30% | |
| Knee arthroscopy | $500 per procedure* | $500 per procedure*, then 30% | |
| Knee, hip replacement | $500 per procedure* | $500 per procedure*, then 30% | |
| Knee, hip resurfacing | $500 per procedure* | $500 per procedure*, then 30% | |
| Shoulder arthroscopy | $500 per procedure* | $500 per procedure*, then 30% | |
| Sinus surgery | $500 per procedure* | $500 per procedure*, then 30% | |
| Spine procedures | $500 per procedure* | $500 per procedure*, then 30% | |
| Bariatric surgery | $500 per procedure* | Not covered | |
| | | | |
| **Maternity Services** | | | |
| Breastfeeding | | | Section 7.6.2 |
| Support and Counseling | No cost sharing | 30% | |
| Breast Pump and Supplies | No cost sharing | No cost sharing | |

| Services | Amount You Pay<br>Deductible applies unless noted differently<br>In-network | <br><br>Out-of-network | Section in Handbook & Details |
|---|---|---|---|
| | | | |
| Fertility services | | | Section 7.6.8 |
| Assistance Reproductive Technology Services (ARTs) and Artificial Insemination | No cost sharing | No cost sharing | $25,000 annual maximum for medical expenses |
| Other Fertility Services | 50%** | 50%** | |
| Maternity | | | Section 7.6 |
| Facility Charges | $50 per day/$250 per admission | $500* per admission then 40% | Section 7.6.7 |
| Prenatal Visits | No cost sharing | 30% | |
| Professional Delivery and Postnatal | No cost sharing | 30% | |
| Newborn Nursery Care | First visit covered at no cost sharing, then $50 per day/$250 per admission | $500* per admission then 40% | Section 7.6.7 |
| | | | |
| **Pharmacy** | | | |
| Prescription Medications | | | Section 7.7 |
| Retail Pharmacy | | | Up to 30-day supply per prescription, and up to 90-day supply at participating retail pharmacies*** |
| Value Tier | No cost sharing | No cost sharing | |
| Generic Tier | $10 | $10 | |
| Brand Tier | $30 | $30 | |
| Mail Order Pharmacy | | | 90-day supply per prescription |
| Value Tier | No cost sharing | N/A | |
| Generic Tier | $25 | N/A | |
| Brand Tier | $75 | N/A | |
| Specialty Pharmacy | | | Up to 30-day supply per prescription for most medications**** |
| Generic Tier | $10 | N/A | |
| Brand Tier | $100 | N/A | |
| Self-administered Chemotherapy Medications | | | Up to 30-day supply per prescription |
| Retail Pharmacy | $10 | $10 | |
| Specialty Pharmacy | $10 | N/A | |

* Copayment does not apply to the medical out-of-pocket maximums.
** Coinsurance does not apply to the medical out-of-pocket maximums.
***The copay for a 90-day supply at participating retail pharmacies would be 2.5 times the copay for the 30-day supply.
**** When allowed, the copay for a specialty pharmacy 90-day supply is 2.5 times the copay for a 30-day supply.

# SECTION 4. PAYMENT & COST SHARING

## 4.1 ADDITIONAL COST TIER

Some surgical procedures have less invasive options. When you get these procedures, you will have to pay a copayment in addition to the standard cost sharing. This copayment still applies if you try the less invasive options first. Additional cost tier procedures include the following:

$100 cost tier:

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

$500 cost tier:

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

Some Additional Cost Tier services will require prior authorization (see Section 6). A full list of services requiring prior authorization may be found on the Moda Health website. More information is on your Member Dashboard, or ask Customer Service for more information about the additional cost tier. Also see sections 7.5.38 and 7.5.11 for imaging and surgery benefits generally.

## 4.2 DEDUCTIBLES

The Plan has separate annual medical and pharmacy deductibles. All amounts for medical services accumulate separately. Every year, you will have to pay some expenses before the Plan starts paying. This is called meeting or satisfying your deductible. The deductible is lower when you use in-network providers. You must pay all covered expenses until you have spent the deductible amount, unless the Plan specifically says there is no deductible for a specific service. Then the Plan begins sharing costs with you. The deductible amounts, and the amount you pay after the deductible is met, are shown in Section 3. In-network and out-of-network services have separate deductibles. If more than one member of your family is covered, you only have to pay your per member deductible until the total family deductible is reached. Copayments, prescription drug out-of-pocket expenses, and disallowed charges do not count toward your annual medical deductible.

Generic and brand drugs dispensed at retail, specialty and mail order pharmacies are subject to the pharmacy deductibles (as shown in Section 3.), which is calculated separately from any other deductible that may apply to the Plan. Covered prescription drug expenses, whether received in-network or out-of-network, accumulate toward the pharmacy deductible. After the deductible has been satisfied, benefits will be paid according to Section 3. Manufacturer discounts and/or copay assistance programs do not count toward your annual pharmacy deductible.

If you have medical covered expenses under this Plan in the last 3 months of the calendar year that count toward your deductible for that year, they will also be carried forward and applied to your deductible but not the maximum cost sharing for the following year.

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

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

## 4.3 ANNUAL MAXIMUM OUT-OF-POCKET

The Plan has a per member and per family annual out-of-pocket maximum for in-network and out-of-network medical expenses. Once you have paid the maximum amount, the Plan will pay 100% of covered services and supplies for the rest of the year, except for services that are not applicable to the out-of-pocket maximums and that do not qualify as essential health benefits. If more than one member of your family is covered, the per member maximum applies only until the total family out-of-pocket maximum is reached, even if no single family member has reached the per member maximum. In-network and out-of-network out-of-pocket maximums add up separately and are not combined.

The Plan has separate per member and per family out-of-pocket maximums for pharmacy medication expenses (as shown in Section 3, which is calculated separately from any other out-of-pocket limit that may apply to the Plan. Expenses incurred due to brand substitution do not accrue to the out-of-pocket maximum. Once the out-of-pocket maximum is met, covered prescriptions will be reimbursed at 100%.

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

You will always have to pay the following costs, even after your out-of-pocket maximum is met:

a. Medical and pharmacy deductibles
b. Cost sharing for office visits to naturopaths, chiropractors, massage therapists and acupuncturists
c. Cost sharing for emergency services
d. Cost sharing for imaging services
e. Cost sharing for fertility services
f. Cost sharing for hearing exams and hearing aids
g. Cost sharing for sleep studies
h. Cost sharing for spinal manipulation, massage therapy and acupuncture
i. Cost sharing for additional cost tier
j. Cost sharing for non-essential health benefits
k. Disallowed charges

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

## 4.4 MAXIMUM COST SHARE

The maximum cost share is the annual limit on cost sharing for essential health benefits as required under the Affordable Care Act (ACA). Except as noted below, members' cost sharing towards deductibles, copayments and coinsurance for essential health benefits performed by an in-network provider accumulates toward the annual maximum cost share. If coverage is for more than one member, the per member maximum applies only until the total family maximum cost share is reached. After the per member or per family annual maximum cost share is met, the Plan will pay 100% of essential health benefits for the remainder of the year. For out-of-network providers, the Plan will continue to pay as shown in Section 3.

The maximum cost share is different from the out-of-pocket maximums and can only be met by cost sharing for in-network covered expenses that qualify as essential health benefits. Cost sharing applied to the in-network out-of-pocket maximums also applies to the maximum cost share.

Essential health benefits include the following categories:

a. Ambulatory services
b. Emergency services
c. Hospitalization
d. Maternity and newborn care
e. Mental health and substance abuse disorder service
f. Prescription medications
g. Rehabilitative and habilitative services and devices
h. Laboratory tests
i. Preventive and wellness services and chronic disease management
j. Pediatric services including oral and vision care, if any

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

a. Services in excess of any maximum
b. Services performed by out-of-network providers
c. Massage therapy
d. Expenses incurred due to brand substitution
e. Manufacturer discounts and/or copay assistance programs
f. Fees in excess of maximum plan allowance
g. Other services that do not qualify as essential health benefits
h. Premiums and penalties
i. Disallowed charges

## 4.5 PAYMENT

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

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

## 4.6 EXTRA-CONTRACTUAL SERVICES

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

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

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

# SECTION 5. NETWORK INFORMATION

When you use a PCP 360, you will receive quality healthcare and will have a higher level of benefits. Use Find Care on your Member Dashboard to choose an in-network provider. You may contact Customer Service if you need help. Your member ID cards will list your network.

Remember to ask providers to send any lab work or x-rays to an in-network facility for the highest benefits.

When you choose an out-of-network provider, you will get out-of-network benefits for those services. See section 5.2 for more information.

## 5.1 GENERAL NETWORK INFORMATION

### 5.1.1 Network and Service Area

Your network provides services in your service area. Subscribers must reside or work within the primary service area. Subscribers who move outside of their network service area must contact Customer Service to find out if another network is available, so you can continue to access in-network providers.

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

**Networks**
Medical network is Synergy, available to members residing or working in Oregon.

Pharmacy network is ArrayRx Core Network

### 5.1.2 Out-of-Area Network for Children

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

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

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

**Out-of-Area Networks**
Children who live in Alaska: First Health Network
Children who live in Idaho: Synergy and First Health Network
For all children who live in other states: Aetna PPO Network

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

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

### 5.1.3 Travel Network

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

You may only use a travel network provider if:

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

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

**Travel Network**
Aetna PPO Network

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

### 5.1.4 Out-of-Network Care

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

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

**Special Circumstances**
We will pay an out-of-network provider at the in-network benefit level when you need emergency care (section 7.3) or for continuity of care (section 10.3). We may also allow the in-network benefit level in these situations:

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

In-network benefits are not automatic (except for emergency services). You or your provider must ask us to prior authorize in-network benefits (see section 6.1). We will review your request, and if the criteria are met, we will pay at the in-network benefit level. You will have to pay any charges that are over the maximum plan allowance.

### 5.1.5 Care after Normal Office Hours

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

## 5.2 COORDINATED CARE MODEL

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

### 5.2.1 PCP 360

The Plan provides the highest benefit level when members have selected and use a PCP 360. A PCP 360 is a healthcare clinic or professional provider who specializes in family practice, general practice, internal medicine or pediatrics, and has been recognized for their commitment to patient-centered care. At enrollment, members are required to select a PCP 360 as their primary care provider (section 5.2.2).

The PCP 360 you choose will coordinate your medical care and arrange for care from specialists and prior authorizations. These providers have an on-call system to provide 24-hour service. If you need to contact your PCP 360 provider after normal office hours, call the regular office number.

If you do not select and properly utilize the services of a PCP 360, your claims will be paid at the out-of-network benefit level. Members who did not select a PCP 360 at the time of enrollment will need to inform Moda Health of the selection prior to receiving treatment.

### 5.2.2 How to select a PCP 360

You must choose an in-network PCP 360 and tell us who it is when you enroll. Each covered family member may choose the same or a different PCP 360, depending upon their needs and preference. Enrolled children may choose a pediatrician and female members may designate a women's healthcare provider as their PCP 360. You may find a PCP 360 online by using Find Care on your Member Dashboard. Contact the PCP 360 to make sure they are accepting new patients. Once a PCP 360 has been selected, you should communicate your selection to Moda Health in one of the following ways before receiving services:

a. Online: Once you have received your medical ID card, you can utilize your Member Dashboard account to indicate the selected PCP 360 for each covered family member
b. Phone: Contact a Health Navigator

To change the PCP 360 selection, you will need to select your new PCP 360 and communicate the change to Moda Health using the options provided above.

### 5.2.3 PCP 360 Primary Care Providers

Your PCP 360 is the first professional provider you should go to for medical care.

Your PCP 360 will provide and/or coordinate all of your healthcare needs. If your PCP 360 is unavailable, the clinic will arrange for another in-network professional provider to be responsible

for your care. If your PCP 360 refers you to a specialist, the specialist will take care of any prior authorizations you need.

You should contact your PCP 360, identify the network you use, arrange for medical records to be transferred, if needed, and find out how to contact the PCP 360 after office hours. This is the first step in establishing a relationship with your PCP 360.

### 5.2.4 Other In-Network Primary Provider Care

You may use any in-network provider, however, care should be coordinated by your PCP 360. There are prior authorization requirements for certain services (see Section 6). You may see an in-network women's healthcare provider instead of the PCP 360 for preventive women's health exams and other gynecological care and for pregnancy care. A women's healthcare provider is an in-network obstetrician or gynecologist, physician assistant or advanced registered nurse practitioner specializing in women's health, or certified nurse midwife, practicing within their lawful scope of practice. To select a women's healthcare provider as your PCP 360, they must meet certain standards and must have requested designation from us as a PCP 360.

### 5.2.5 Out-of-Network Provider Care

We work with your PCP 360s to encourage them to refer you to in-network providers whenever possible. These providers have agreed to cooperate in our quality assurance and utilization review programs. You may have to pay all of the charges when you get the treatment, and then file a claim to get your benefits. If the provider's charges are over the maximum plan allowance, you may be balance billed and have to pay those excess charges.

## 5.3 USING FIND CARE

Find Care is our online directory of in-network providers. To search for in-network providers, log in to your Member Dashboard at modahealth.com/pebb and click on Find Care.

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

### 5.3.1 PCP 360 Providers

To find a PCP 360 provider:

a. Choose the "PCP 360" option under the Type drop down menu
b. Enter ZIP code, Search Radius and Search

The search will bring up a list of PCP 360s. These providers will have a PCP 360 badge icon next to their contact information.

# SECTION 6. PRIOR AUTHORIZATION

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

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

## 6.1 PRIOR AUTHORIZATION REQUIREMENTS

When you use an out-of-network provider, you are responsible for making sure that your provider contacts us for prior authorization. If your advanced imaging services are not authorized in advance, the Plan will not pay any benefits. You will have to pay the full charge.

Any amounts that you have to pay because you did not get a prior authorization do not count toward your deductible or out-of-pocket maximum.

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

Prior authorization is not required for an emergency admission.

If your services are not authorized in advance, the Plan will not pay any benefits if the service does not meet our criteria for being medically necessary. When you use an out-of-network provider, you are responsible for ensuring that your provider contacts us for prior authorization. If your provider is out-of-network, you will have to pay the full charge. In-network providers will get prior authorization for you. If your in-network provider does not get prior authorization when required, they must write off the full charge of the service.

### 6.1.1 Services Requiring Prior Authorization

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

a. Inpatient services and residential programs
b. Outpatient services
c. Rehabilitation (physical, occupational, speech therapy)
d. Diagnostic services, including imaging services
e. Infusion therapy
f. Coordinated specialty programs

g. Disease management for pain
h. Medications

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

### 6.1.2 Prior Authorization Limitations

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

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

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

### 6.1.3 Second Opinion

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

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

# SECTION 7. BENEFIT DESCRIPTION

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

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

Many services must be prior authorized (see section 6.1.1). Sometimes you will have to use a certain provider for the service. If your services are not authorized in advance or you do not use the authorized provider, the Plan may not pay any benefits. You may have to pay the full charge.

## 7.1 YOUR RESPONSIBILITY IN THE PLAN

You are responsible for:

a. Selecting and using a PCP 360 who is in your network
b. Actively working with your PCP 360 and any other professional provider treating you to make sure all your care is being provided in-network. You may have to pay some or all of the charges for care you get from out-of-network providers

## 7.2 WHEN BENEFITS ARE AVAILABLE

The Plan only pays claims for covered services you get when your coverage is in effect. Coverage is in effect when:

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

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

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

## 7.3 URGENT & EMERGENCY CARE

Care received outside of the United States is only covered for an urgent care or emergency medical condition. Emergency services are covered at the in-network benefit level. If you get emergency care outside the United States, you will have to pay for those services at that time and send a claim to us (as described in section 10.1.1).

### 7.3.1 Ambulance Transportation (Including Emergency Medical Transportation)

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

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

### 7.3.2 Emergency Room Care

You are covered for treatment of emergency medical conditions (as defined in Section 12) worldwide. When you believe you have a medical emergency, call 911 or seek care from the nearest appropriate provider.

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

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

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

Prior authorization is not needed for emergency services including medical screening exams or treatment to stabilize an emergency medical condition, or treatment or stabilization as part of an outpatient observation or an inpatient or outpatient stay except if the attending physician determines you are able to travel using nonmedical or nonemergency medical transportation to an in-network facility, the out-of-network facility or provider meets the notice and consent requirements, and you receive the notice and give informed consent. Let your PCP 360 know as soon as possible about any emergency care that you receive.

### 7.3.3 Emergencies and Urgent Care Outside the Service Area

If you are outside of the service area when you have a medical emergency, seek medical attention from the nearest appropriate facility or call 911. Let your PCP 360 know about any emergency care you receive within 24 hours, or as soon as possible. You must get a referral from your PCP 360 for any follow-up care. If you do not, the follow-up care that is not considered an emergency service will be paid at the out-of-network benefit level.

If you must be admitted to an out-of-network facility, your PCP 360 and Moda Health's medical director will monitor your condition. When they determine you can be safely transferred to an in-network facility, the Plan will stop paying in-network benefits for care at the out-of-network facility.

The in-network benefit level is not available for out-of-network care that is not emergency medical care, unless we have approved your PCP 360's prior authorization request. We will not approve unless the service is not available in your network. These are some examples of services

that are not emergency medical conditions and are not eligible for the in-network benefit level (this list is not inclusive of all such services):

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

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

### 7.3.4 Emergency Eye Care Services

The Plan covers eye care services provided by an optometrist, an ophthalmologist or a hospital emergency room for emergency medical conditions without a referral or prior authorization from a PCP 360.

### 7.3.5 Urgent Care

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

## 7.4 PREVENTIVE SERVICES

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

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

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

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

### 7.4.1 Colorectal Cancer Screening.

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

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

These screening timelines apply to you if you are not at high risk for colorectal cancer. You may be screened earlier or more often if it is medically necessary. If you have a positive result on a USPSTF recommended screening covered under the preventive benefit, one follow-up colonoscopy will also be covered under the preventive benefit.

Anesthesia that is medically necessary for colorectal cancer screening is covered under the preventive benefit. If the anesthesia is determined not medically necessary, it is not covered.

If you are at high risk for colorectal cancer, screening exams and laboratory tests are covered as recommended by your professional provider. They are paid at the medical benefit level if you do not meet the criteria for the USPSTF A or B rated recommendation. If you have a family medical history of known genetic disorders that predispose you to a high lifetime risk of colorectal cancer (such as Lynch syndrome), you have had colorectal cancer or an adenomatous polyp before, or you have had inflammatory bowel disease, you are high risk.

### 7.4.2 Contraception

All FDA approved contraceptive methods, including sterilization, and counseling are covered. When you use an in-network provider and the most cost effective option (e.g., generic instead of brand name), you will not have to pay for contraception. If there is not an in-network provider within a reasonable distance who can provide timely, cost-effective contraceptive services to you, ask Customer Service for help. We may prior authorize services at no cost sharing with an out-of-network provider. If your provider determines the cost effective contraception is medically inadvisable, we will cover an alternative that they prescribe. Over the counter contraceptives are covered under the Pharmacy benefit (section 7.7).

### 7.4.3 Immunizations

Routine immunizations are limited to those recommended by the ACIP. Immunizations for the purpose of travel are covered when recommended by the Disease Control and Prevention (CDC), but for the sole purpose to prevent illness that may be caused by a work environment are not covered.

### 7.4.4 Pediatric Screenings

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

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

### 7.4.5 Preventive Health Exams

Covered according to the following schedule:

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

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

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

### 7.4.6 Routine Prostate Rectal Exam & Prostate Specific Antigen (PSA) Test

If you are age 50 or over, the Plan covers one rectal examination and one PSA test every year or as determined by the treating professional provider. If you are at high risk for prostate cancer, a prostate rectal exam and PSA test are covered earlier or more often if your professional provider recommends it.

### 7.4.7 Tobacco Cessation

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

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

### 7.4.8 Women's Healthcare

Preventive women's healthcare visits, including one pelvic and breast exam and one Pap test each year. Breast exams are limited to women 18 years of age and older. Mammograms are limited to one between the ages of 35 and 39, and one per year age 40 and older.

Pap tests and breast exams, and mammograms for screening or diagnosis if you have symptoms or are high risk are also covered when your professional provider decides it is necessary. These are covered under the office visit, x-ray or lab test benefit level if they are not within the Plan's age and frequency limits for preventive screening.

A woman may see a women's healthcare provider instead of the PCP 360 for preventive women's health exams. This includes follow-up visits resulting from an exam covered under this provision. However, the follow-up visits and related treatment are eligible only if the services are covered (this includes x-rays, laboratory tests or surgery). The women's healthcare provider should keep the PCP 360 informed of the medical care being provided.

## 7.5 GENERAL TREATMENT SERVICES

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

### 7.5.1 Acupuncture

A limited number of visits are covered each year. Other services you may get at an acupuncture visit, such as office visits or lab and diagnostic services are not covered under this benefit. They are paid under the Plan's standard benefit for the type of service.

### 7.5.2 Anticancer Medication

Prescribed anticancer medications, including oral, intravenous (IV) or injected medications, are covered. Most anticancer medications need to be prior authorized and have specific benefit limitations. You must get specialty anticancer medications from our designated specialty pharmacy (see section 7.7.5). For some anticancer medications, you may have to enroll in programs to help make sure the medication is used correctly and/or lower the cost of the medication. You can find more information on your Member Dashboard or by contacting Customer Service.

### 7.5.3 Applied Behavior Analysis (ABA)

Applied behavior analysis (ABA) is a type of treatment for individuals with autism spectrum disorder (formerly called pervasive developmental disorder). ABA is a variety of psychosocial interventions that use behavioral principles to shape behavior. It includes direct observation, measurement and functional analysis of the relationship between environment and behavior. Goals include improving daily living skills, decreasing harmful behavior, improving social functioning and play skills, improving communication skills and developing skills that result in greater independence. ABA for autism spectrum disorder is covered. Services must be prior authorized.

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

Examples of what we do not cover:

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

### 7.5.4 Bariatric Surgery

In-network medically necessary bariatric surgery services, limited to gastric bypass, gastric stapling, gastroplasty, gastric sleeve, and the Lap-Band adjustable gastric banding system, are covered if you meet all of the following requirements:

a. Meet the clinical criteria including body mass index (BMI) equal to or greater than 35 with a diagnosis of diabetes, BMI equal to or greater than 40 with any obesity related comorbid condition such as obstructive sleep apnea, treated hypertension, treated diabetes or cardiac disease), or BMI equal to or greater than 50 with or without obesity related comorbid conditions
b. Complete a 6-month work up that includes dietary counseling and education, medical and psychological evaluation and a weight loss of greater than 5% during the work up period
c. Prior authorize and obtain approval after the 6-month work up period
d. Services must be received at a center of excellence facility that
    i. Moda Health has arranged or contracted with to provide bariatric surgery and
    ii. meets the Health Evidence Review Commission guidelines for facilities providing bariatric surgery

### 7.5.5 Biofeedback

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

### 7.5.6 Breast Reduction Surgery

Breast reduction services are covered when medically necessary. Breast surgeries for cosmetic purposes are excluded as described in section 7.5.38.

### 7.5.7 Child Abuse Medical Assessment

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

### 7.5.8 Clinical Trials

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

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

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

The Plan does not cover items or services:

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

### 7.5.9 Dental Injury

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

To be covered all of the following must be true:

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

Covered treatment is limited to that which will restore teeth to a functional state, including bridges, implants and implant related services. Exceptions to the timelines may be made when medically necessary.

### 7.5.10 Diabetes Services

Insulin and diabetic supplies including insulin syringes, needles and lancets, test strips, glucometers and continuous glucose monitors are covered under the pharmacy benefit (section 7.7.1) when you buy them from a pharmacy with a valid prescription. Insulin pumps may be covered under the DME benefit (section 7.5.13) if you do not get them from a pharmacy.

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

a. HbA1c lab test
b. Checking for kidney disease
c. Annual dilated eye exam or retinal imaging, including one by an optometrist or ophthalmologist
d. Diabetes self-management programs
    i. One diabetes assessment and training program after you are diagnosed with diabetes
e. Dietary or nutritional therapy
f. Routine foot care (see section 7.5.32)

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 to get this maternal diabetes benefit.

### 7.5.11 Diagnostic Procedures

Services must be for treatment of a medical or mental health condition. Some of these procedures may need to be prior authorized. Diagnostic services include:

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

Your provider must get prior authorization for most advanced imaging services (see Section 6). This includes radiology (such as MR procedures like MRI and MRA, CT, PET and nuclear medicine) and cardiac imaging. A full list of diagnostic procedures that must be prior authorized is on the Moda Health website or you may ask Customer Service.

### 7.5.12 Disease Management for Pain

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

### 7.5.13 Durable Medical Equipment (DME), Supplies & Appliances

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

Some examples of covered DME, supplies and appliances are:

a. CPAP for sleep apnea
b. Glasses or contact lenses, if you have aphakia or keratoconus
c. Hospital beds and accessories
d. Insulin pumps
e. Intraocular lenses within 90 days of cataract surgery
f. Light boxes or light wands
g. Orthotics, orthopedic braces, orthopedic shoes to restore or maintain your ability to do day to day activities or perform your job. If you can get the correction or support you need by modifying a mass-produced shoe, then we will only cover the cost of the modification.
h. Oxygen and oxygen supplies
i. Prosthetics

Diabetic supplies, other than insulin pumps and related supplies, are only covered when you get them from a pharmacy. You must have a prescription and use a preferred manufacturer (see section 7.7 for coverage under Pharmacy benefit).

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

All supplies, appliances and DME must be medically necessary. Your provider may have to prior authorize some DME (see Section 6). Replacement or repair is only covered if the appliance, prosthetic device, equipment or DME was not abused, was not used beyond its specifications and not used in a way that voids its warranty. If we ask you to, you must authorize anyone supplying

your DME to give us information about the equipment order and any other records we need to approve a claim payment.

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

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

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

### 7.5.14 Electrolysis
Facial electrolysis is covered if you have a diagnosis of polycystic ovary syndrome (PCOS) and hirsutism.

### 7.5.15 Electronic Visits (E-Visits)
An electronic visit (e-visit) is a structured, secure online email consultation between a PCP 360 and the member. The Plan covers e-visits when the following conditions are met:

a. You have previously been treated in the PCP 360 provider's office within the last 12 months and are established as a patient
b. The e-visit is medically necessary for a covered medical condition

Email communications including those to renew prescriptions, schedule tests or appointment, report normal test results, recommend a referral to another physician, follow up an office visit, confirm stability of a chronic problem and continuity of present management of the problem, or communicate information related to mental health or substance use disorder services, are not covered.

### 7.5.16 Gender Confirming Services
To be eligible for coverage, all services must be medically necessary.

Coverage includes:

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

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

a. The procedure(s) must be performed by a qualified professional provider

b. The professional provider must obtain prior authorization for the surgical procedure
c. The treatment plan must meet medical necessity criteria
d. Surgical procedures (see section 7.5.38):
    i. Breast/chest surgery
    ii. Gonadectomy (hysterectomy/oophorectomy or orchiectomy)
    iii. Reconstruction of the genitalia
    iv. Gender confirming facial surgery performed by a provider at a defined network of Center of Excellence facilities. Please note not all in-network providers are considered part of the Centers of Excellence for this benefit. You may go to www.modahealth.com/pebb or contact a Health Navigator to locate a provider at a Center of Excellence facility.
e. The following procedures are excluded, unless the specific medical necessity criteria are met for the procedure requested:
    i. Blepharoplasty
    ii. Hair removal for surgical reconstruction (i.e. genital hair removal)
    iii. Breast augmentation procedures
    iv. Voice therapy/voice modification
    v. Removal of redundant skin (i.e. Panniculectomy)

The following services are not medically necessary for all medical conditions and are **excluded** from coverage by the Plan as part of gender identity disorder treatment:

a. Lip enhancement
b. Liposuction/abdominoplasty of the waist (body contouring)
c. Voice modification surgery (laryngoplasty or shortening of the vocal cords)
d. Skin resurfacing used in feminization
e. Lip reduction
f. Collagen injections
g. Reversal or removal of gender reassignment surgery
h. Make up evaluation
i. Legal expenses related to name change

**Definitions**

**Center of Excellence** is a facility and/or team of professional providers with which Moda Health has contracted and arranged to provide gender confirming facial surgery services. Centers of Excellence follow best practices, and have exceptional skills and expertise in managing patients with a specific condition.

### 7.5.17 Hearing Services

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

We cover these items once every 3 years:

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

We also cover:

a. Ear molds and replacement ear molds 4 times per year if you are under age 8 and once per year if you are age 8 or older
b. One box of replacement batteries per year for each hearing aid

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

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

### 7.5.18 Home Healthcare

If you are homebound, home healthcare services and supplies from a home healthcare agency are covered. Homebound means that you generally cannot leave home because of your condition. If you do leave home, it must be infrequent, for short times, and mainly to get medical treatment. A home healthcare agency is a licensed public or private agency that specializes in providing skilled nursing and other therapeutic services, such as physical therapy, in your home.

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

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

Home health visits have a calendar year maximum. Home health aides are not covered. If you are in hospice, your home healthcare, home care services and supplies are covered under sections 7.5.19 and 7.5.13. Home healthcare requires prior authorization.

### 7.5.19 Hospice Care

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

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

**Hospice Home Care**

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

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

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

**Hospice Inpatient Care**
Short-term hospice inpatient services and supplies are covered.

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

**Exclusions** In addition to exclusions listed in Section 8, the Plan does not cover:

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

### 7.5.20 Hospital Care
Facility care will only be covered when it is medically necessary. Covered expenses for hospital care are:

a. Hospital room
b. Isolation care to protect you or other patients from spreading illness
c. Intensive care unit
d. Facility charges for surgery performed in a hospital outpatient department
e. Other hospital services and supplies when medically necessary for treatment and ordinarily provided by a hospital
f. Take-home prescription drugs are limited to a 3-day supply at the same benefit level as hospitalization

All inpatient and residential stays must be prior authorized (see Section 6).

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

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

### 7.5.22 Inborn Errors of Metabolism

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

### 7.5.23 Infusion Therapy

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

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

Your provider must get prior authorization for infusion therapy. You may have to use a preferred medication supplier, home infusion provider or provider office infusion for some medications. When we limit authorization to a certain provider or setting, medications you get from other suppliers or infusion therapy administered at a hospital outpatient facility or other in-network provider may not be covered. Some infusion medications from a preferred medication supplier are covered under the pharmacy specialty medication benefit (see Section 3 and section 7.7.4). See section 7.7.5 for self-administered infusion therapy. Some services and supplies are not covered if your provider bills separately. They are considered included in the cost of other billed charges.

### 7.5.24 Kidney Dialysis

Covered expenses include:

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

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

### 7.5.25 Massage Therapy

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

### 7.5.26 Maxillofacial Prosthetic Services

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

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

The problem must be because of:

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

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

### 7.5.27 Medication Administered by Provider, Treatment/Infusion Center or Home Infusion

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

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

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

See section 7.5.23 for more information about infusion therapy. Self-administered medications are not covered under this benefit (see section 7.7.5). See section 7.7 for pharmacy benefits.

### 7.5.28 Mental Health

These services by a mental health provider are covered:

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

Intensive outpatient treatment and TMS must be prior authorized. Coordinated specialty programs must be prior authorized or authorized as soon a reasonably possible after you start them. See section 7.5.11 for coverage of diagnostic services.

Intensive outpatient services are more intensive than routine outpatient and less intensive than a partial hospital program. Mental health intensive outpatient is 3 or more hours per week of direct treatment. A partial hospital program is an appropriately licensed mental health facility providing no less than 4 hours of direct, structured treatment services per day. Partial hospital programs do not provide overnight 24-hour care.

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

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

Coordinated Specialty Programs are:

a. Crisis and Transition Services (CATS) programs operating under contract with the Oregon Health Authority
b. Early Assessment and Support Alliance (EASA) and Assertive Community Treatment (ACT) provided by Community Mental Health Programs
c. Intensive Outpatient Services and Supports (IOSS)
d. Intensive In-Home Behavioral Health Treatment (IBHT)

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

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

### 7.5.30 Nutritional Therapy
Nutritional therapy for eating disorders is covered when medically necessary. It must be authorized after the first 5 visits. Preventive nutritional therapy required under the Affordable Care Act is covered under the preventive care benefit. Also see diabetes services (section 7.5.10) and inborn errors of metabolism (section 7.5.22).

### 7.5.31 Office or Home Visits
A visit means you are actually examined by a professional provider, including naturopathic, chiropractic and acupuncture visits. Covered expenses include consultations with written reports and second opinion surgery consultations. Ancillary services (such as lab tests) received in conjunction with the office visits are subject to the standard cost sharing.

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

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

### 7.5.34 Rehabilitation & Habilitation
Covered rehabilitative services are:

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

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

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

Rehabilitative services have an annual limit. The limit does not apply to medically necessary cardiac or pulmonary rehabilitation or services for mental health and substance use disorder. We may cover more sessions or days if you have an acute head or spinal cord injury or a stroke. To get these additional benefits, you must meet the criteria and your provider must get prior authorization before you have used all of your initial sessions or visits. A session is one visit. Only one session of each type of outpatient physical, occupational or speech therapy is covered in one day.

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

Habilitative services are used to form skills that you never developed due to a medical condition. Habilitative services are only covered when it is medically necessary to treat a mental health condition.

### 7.5.35 Skilled Nursing Facility Care

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

**Exclusions**

These skilled nursing facility charges are not covered:

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

### 7.5.36 Spinal Manipulation

A limited number of visits are covered each year. Other services you may get at a spinal manipulation visit, such as office visits, lab and diagnostic x-rays, or physical therapy are not covered under this benefit. They are paid under the Plan's standard benefit for the type of service.

### 7.5.37 Substance Use Disorder Services

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

Outpatient treatment programs are state-licensed programs that provide an organized outpatient course of treatment, with services by appointment, for substance use disorders.

Intensive outpatient services are more intensive than routine outpatient and less intensive than a partial hospital program. Substance use disorder intensive outpatient is 9-19 hours per week for adults or 6-19 hours per week for adolescents.

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

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

Room and treatment services for substance use detoxification by a state-licensed treatment program are covered.

### 7.5.38 Surgery

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

The surgery cost sharing also applies to these services:

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

Some Additional Cost Tier services will require prior authorization (see section 4.1 and Section 6). A full list of services requiring prior authorization may be found on the Moda Health website. Visit your Member Dashboard or contact Customer Service for more information regarding the Additional Cost Tier.

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

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

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

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

Surgery for breast enhancement, making breast match, and replacing breast implants to change the shape or size of your breasts is not covered except to treat gender dysphoria (see sections 7.5.16) or after a mastectomy.

Reconstructive surgery after a medically necessary mastectomy includes:

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

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

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

### 7.5.39 Temporomandibular Joint Syndrome (TMJ)
TMJ related services are covered including:

a. A diagnostic exam including a history, physical examination and range of motion measurements as necessary
b. Diagnostic x-rays
c. Physical therapy of necessary frequency and duration up to an annual limit
d. Therapeutic injections
e. Benefits for a single appliance or splint as part of a therapy that does not permanently alter tooth position, jaw position or bite.

TMJ related surgery and treatment of related dental diseases or injuries, such as dental or orthodontia services, are excluded.

### 7.5.40 Therapeutic Injections
Administrative services for therapeutic injections, such as allergy shots, are covered when you get them in a professional provider's office. When you can get similar results with self-administered medications at home, the administrative services for therapeutic injections by your provider are not covered. Vitamin and mineral injections are not covered unless they are

medically necessary to treat a specific medical condition. More information is in sections 7.5.27 and 7.7.5.

### 7.5.41 Therapeutic Radiology

Covered expenses include:

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

### 7.5.42 Transplants

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

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

We cover medically necessary transplants that follow standard medical practice and are not experimental or investigational. Your doctor should get prior authorization as soon as possible after you know you may be a possible transplant candidate. This section's requirements do not apply to corneal transplants and collecting and/or transfusing blood or blood products (see section 7.5.38).

Benefits for transplants are limited as follows:

a. Transplant procedures must be done at a Center of Excellence. If a Center of Excellence cannot provide the necessary type of transplant, we will prior authorize services at another transplant facility.
b. Donor costs are covered as follows:
    i. If you are the recipient or self-donor, donor costs related to a covered transplant are covered. If the donor is also enrolled in the Plan, expenses resulting from complications and unforeseen effects of the donation are covered.
    ii. If you are the donor and the recipient is not enrolled in the Plan, the Plan will not pay any benefits toward donor costs.
    iii. If the donor is not enrolled in the Plan, expenses that result from complications and unforeseen effects of the donation are not covered.
c. Travel expenses for the recipient are subject to a $5,000 combined maximum for transportation, food and lodging. Food and lodging is also subject to a $150 daily limit.
d. Professional provider transplant services are paid according to the benefits for professional providers.
e. Immunosuppressive drugs you get during a hospital stay are paid as a medical supply. Outpatient oral and self-injectable prescription medications for transplant related services are paid under the Pharmacy Prescription benefit (section 7.7).
f. 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.

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

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

### 7.5.43 Travel Reimbursement

Travel and lodging reimbursement may be available if you are unable to find a nearby in-network provider to provide medically necessary covered services for your specific condition due to one of the following reasons:

a. An in-network provider is not available within 50 miles of your home
b. Covered services are not available in your state due to a law or regulation, and the services can be received in another state legally
c. A center of excellence is recommended

The Plan may reimburse the patient and one adult companion's travel and lodging expenses to the nearest in-network provider. Per diem and mileage limitations are based on the federal government allowances from the US General Services Administration (GSA). Food and lodging is subject to a $150 daily limit. Receipts for travel expenses must be submitted as proof of payment. Travel and lodging expense reimbursement is limited to $5,000 per calendar year. Reimbursement is subject to the appropriate prior authorization.

### 7.5.44 Virtual Care Visits (Telemedicine)

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

A virtual care visit is covered if:

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

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

## 7.6 MATERNITY CARE

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

Maternity services are usually billed as a global charge. This is a lump sum charge for maternity care that includes prenatal care, labor and delivery, and post-delivery care. Some diagnostic services, such as amniocentesis and fetal stress test, are not part of global maternity services and are reimbursed separately. See section 7.5.10 for gestational diabetes benefits.

If you have a home birth, the only expenses that are covered are the fees billed by a professional provider. Other home birth charges, such as travel and portable hot tubs, are not covered.

Supportive services, such as physical, emotional and informational support to you before, during and after birth and during the postpartum period, are not covered expenses, except under the newborn home visiting program (section 7.6.5).

Maternity care for a member who is serving as a surrogate parent is covered, except to the extent that such services are payable under the surrogate parenting contract or agreement.

### 7.6.1 Abortion

Elective abortions are covered at no cost sharing when performed by an in-network provider. Elective abortion is the member's right to end a pregnancy for reasons other than their health or a fetal disease.

### 7.6.2 Breastfeeding Support

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

### 7.6.3 Circumcision

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

### 7.6.4 Diagnostic Procedures

Diagnostic services, including laboratory tests and ultrasounds, related to maternity care are covered. Some of these procedures may need to be prior authorized.

A full list of services that must be prior authorized is on the Moda Health website, or you may ask Customer Service.

### 7.6.5 Newborn Home Visiting Program

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

Services include:

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

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

### 7.6.6 Office, Home or Hospital Visits

A visit means you are actually examined by a professional provider. In addition to pregnancy care and childbirth visits, nurse home visiting services are covered (see section 7.6.5).

### 7.6.7 Hospital Benefits

Covered hospital maternity care expenses are:

a. Hospital room
b. Facility charges from a covered facility, including a birthing center
c. Nursery care includes one in-nursery well-newborn infant preventive health exam. You will not have to pay anything when your provider is in-network. Additional visits are covered at the hospital visit benefit level. Nursery care is covered under the newborn's own coverage, and is routine while you are in the hospital and receiving maternity benefits.
d. Other hospital services and supplies when medically necessary for treatment and ordinarily provided by a hospital
e. Take-home prescription drugs are limited to a 3-day supply at the same benefit level as for hospitalization

**Special Right Upon Childbirth (Newborns' and Mothers' Health Protection Act)**

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

### 7.6.8 Fertility Services

The Plan covers fertility services including:

a. Assistance Reproductive Technology Services (ARTs) and artificial insemination at no cost sharing up to a $25,000 annual benefit maximum including:

    i. IVF – In-vitro fertilization
    ii. ZIFT – Zygote intra-fallopian transfer
    iii. GIFT – Gamete intra-fallopian transfer
    iv. PGSD – Pre-implantation genetic diagnosis
    v. ICSI – Intracytoplasmic sperm injection
    vi. Ovum microsurgery
    vii. Related prescription medications
    viii. Artificial insemination (including Intrauterine insemination (IUI)), limited to a lifetime maximum of 6 cycles and sperm wash
    ix. Retrieval and storage of eggs and sperm for Fertility Preservation. Examples include medications used to stimulate the ovaries for oocyte (egg) retrieval

Other fertility services includes:

a. Diagnostic testing and related office visits to determine the cause of infertility.
b. Examination, related laboratory testing, and medical and surgical procedures to treat infertility
c. Infertility related medications or injectables
d. Covered infertility-related supplies

The Plan does not cover services for unenrolled surrogate mothers, reversals of voluntary sterilization and procedures determined to be experimental or investigational.

## 7.7 PHARMACY PRESCRIPTION BENEFIT

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

### 7.7.1 Covered Medication Supply

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

a. A prescription medication that is medically necessary to treat a medical condition
b. Compounded medications that have at least one covered medication as the main ingredient
c. Insulin and diabetic supplies including insulin syringes, needles and lancets, test strips, glucometers and continuous glucose monitors. You must have a valid prescription
d. Certain prescribed preventive medications required under the Affordable Care Act
e. Medications to treat tobacco dependence, including OTC nicotine patches, gum or lozenges. You must have a prescription. If you use an in-network retail pharmacy, they are covered with no cost sharing as required under the Affordable Care Act
f. Contraceptive medications and devices for birth control (section 7.4.2) and for medical conditions covered under the Plan. You can get up to a 3-month supply the first time you use the medication and up to a 12-month supply after that. Ask Customer Service how to get a 12-month supply.
g. Certain immunizations and related administration fees are covered with no cost sharing at in-network retail pharmacies (such as flu, pneumonia and shingles vaccines)

Certain prescription medications and/or quantities of prescription medications may need to be prior authorized (see Section 6). You must get specialty medications from a Moda-designated pharmacy.

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

### 7.7.2 Formulary Exception Requests

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

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

We will contact your prescribing professional provider to find out how the medication is being used in your treatment plan. We will make a decision about your exception requests within 72 hours or just 24 hours if your request is urgent. This formulary exception process is not used for

a medication or pharmacy charge that is not covered for other reasons, plan limitations or exclusions.

### 7.7.3 Mail Order Pharmacy

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

### 7.7.4 Specialty Services & Pharmacy

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

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

### 7.7.5 Self-Administered Medication

All self-administered medications follow all the prescription medication requirements of section 7.7. This includes specialty medication requirements (section 7.7.4) when you get a self-administered specialty medication.

Self-administered injectable medications are not covered if you get them in a provider's office, clinic or facility.

### 7.7.6 Step Therapy

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

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

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

### 7.7.7 Limitations

a. New FDA approved medications will be reviewed. We may have coverage requirements or limits. You or your prescriber can ask for a medical necessity evaluation if we do not cover a newly approved medication during the review period.
b. You will need a formulary exception to use a brand medication when a generic equivalent is available. If the exception request is approved, you will have to pay the difference in

cost between the generic and brand medication. These additional costs do not count toward your out-of-pocket maximum or maximum cost share.

c. We may prior authorize certain brand medications for a specific amount of time or until a generic medication becomes available, whichever comes first. When a generic medication becomes available during the authorized period, the brand medication is no longer covered. You can get the generic medication without a new prescription or authorization.
d. Coverage of weight loss drugs is subject to review and will be covered if medical necessity is determined for the medical treatment of weight loss or obesity under the plan.
e. Some specialty medications may be limited to a 2-week supply.
f. Medications with dosing intervals greater than the Plan's maximum day supply will have an increased copayment to match the day supply.
g. Medications you buy outside the United States and its territories are only covered in emergency and urgent care situations.
h. You may ask to have your medication refilled early if you are going to travel outside of the United States. When we allow an early refill, it is limited to once every 6 months. You cannot get an early refill to extend your medication supply beyond the end of the plan year.
i. If you need an emergency refill of insulin or diabetic supplies, we will cover it no more than 3 times per year. We will only cover the smallest available package or a 30-day supply, whichever is less.

### 7.7.8 Exclusions

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

a. **Cosmetic.** Medications, including hormones, prescribed or used for cosmetic purposes.
b. **Devices.** Including, but not limited to therapeutic devices and appliances. Information for contraceptive devices is in section 7.7.1 and for other devices in section 7.5.13
c. **Foreign Medication Claims.** Medications you buy from non-U.S. mail order or online pharmacies or U.S. mail or online pharmacies acting as agents of non-U.S. pharmacies
d. **Hair Growth Medications.**
e. **Institutional Medications.** To be taken by or administered while you are a patient in a hospital, rest home, skilled nursing facility, extended care facility, nursing home or similar institution
f. **Medication Administration.** A charge to administer or inject a medication, except for immunizations or contraceptives at in-network retail pharmacies
g. **Medications Covered Under Another Benefit.** Such as medications covered under home health, medical, etc.
h. **Medications Not Approved by FDA.** Products not recognized or designated as FDA approved medications. This includes medications that are found to be less effective by the FDA's Drug Efficacy Study Implementation (DESI) classifications.
i. **Non-Covered Condition.** A medication prescribed for reasons other than to treat a covered medical condition
j. **Nutritional Supplements and Medical Foods.**
k. **Off-label Use.** Medications prescribed for or used for non-FDA approved indications, unless Oregon's Health Evidence Review Commission or Pharmacy Therapeutics and Review Committee has approved it
l. **Over the Counter (OTC) Medications** and certain prescription medications that have an OTC option, except for those treating tobacco dependence
m. **Repackaged Medications.**
n. **Replacement Medications and/or Supplies.**

o. **Vitamins and Minerals.** Except as required by law
p. **Weight Loss Medications.**

### 7.7.9 90 Day Supply at Participating Retail Pharmacies

You may buy a 90-day supply from participating retail pharmacies at the mail order cost sharing and preferred discount. Not all medications are eligible for a 90-day supply. These benefits apply for supplies of 84 days and greater. All standard benefit and administrative provisions (such as prior authorization and step therapy) apply. Search for participating pharmacies using your Member Dashboard. Participating pharmacies will say “3 months” under the Days Supply column in their details.

### 7.7.10 Definitions

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

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

**Generic Medications** are medications that have been found by the Food and Drug Administration (FDA) to be therapeutically equivalent to the brand option and will often save you money. Generic medications must have the same active ingredients as the brand version and be identical in strength, dosage form and the way you take them. Some generic medications have not been shown to be safer or more effective than other more cost effective generic medications. These high cost generic medications are excluded unless a formulary exception is requested and approved. See section 7.7.2 for more information about making a formulary exception request.

**Nonpreferred Medications.** Nonpreferred medications are excluded unless a formulary exception is requested and approved. These medications have been reviewed by Moda Health and they do not have significant therapeutic advantage over their preferred alternative(s). These medications generally have safe and effective options available under the Value, Generic and/or Brand tiers. See section 7.7.2 for information about making a formulary exception request.

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

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

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

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

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

## SECTION 8. GENERAL EXCLUSIONS

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

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

**Care Outside the United States**
Except for care that is due to an urgent or emergency medical condition

**Charges Over the Maximum Plan Allowance**
Except when required under the Plan's coordination of benefits rules (see section 10.4.1)

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

**Cosmetic Procedures**
Any procedure or medication with the main purpose of changing or maintaining your appearance and that will not result in significant improvement in body function. Examples include rhinoplasty, breast enhancement, liposuction and hair removal (except services described in section 7.5.14). Reconstructive surgery following a mastectomy (section 7.5.38) or as part of gender confirming services (section 7.5.16), and complications of reconstructive surgeries is covered if medically necessary and not specifically excluded.

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

**Dental Examinations and Treatment; Orthodontia**
Except services described in sections 7.5.9 and 7.5.26, or if medically necessary to restore function due to craniofacial irregularity

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

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

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

**Faith Healing**

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

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

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

**Homeopathic Treatment and Supplies**

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

**Infertility**
Donor semen from donor banks or other providers, harvesting and storage of semen other than for immediate use, services for unenrolled surrogate mothers, reversals of voluntary sterilization and procedures determined to be experimental or investigational.

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

**Naturopathy**
Including herbal, naturopathic or homeopathic medicines, substances or devices and any other nonprescription supplements

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

**Non-Therapeutic Counseling**
Including legal, financial, vocational, spiritual and pastoral counseling

**Nuclear Radiation**
Any medical condition arising from ionizing radiation, pollution or contamination by radioactivity from any nuclear waste from the combustion of nuclear fuel, and the radioactive, toxic, explosive

or other hazardous properties of any explosive nuclear assembly or component, unless otherwise required by law.

**Nutritional Counseling**
Except as described in sections 7.5.10 and 7.5.30

**Obesity or Weight Reduction**
Except as covered in sections 2.4.5.1 and 7.5.4

**Orthopedic Shoes**
Except as described in section 7.5.13

**Orthognathic Surgery**
Including associated services and supplies

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

**Pharmacies Excluded from the Network**
Medications from pharmacies that are not allowed to contract with the network. This includes pharmacies that have been excluded from the network for non-compliance with fraud, waste and abuse laws.

**Physical Exercise Programs**
Programs, videos and exercise equipment

**Private Nursing Services**

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

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

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

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

**Self-Administered Medications**
Including oral and self injectable when you get them directly from a physician's office, facility or clinic instead of through the pharmacy prescription medication or anticancer benefits (sections 7.7.5 and 7.5.2).

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

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

**Services for Administrative or Qualification Purposes**
Physical or mental examinations, psychological testing and evaluations and related services for purposes such as:

a. Employment or licensing, except when required to obtain a commercial driver license (CDL) in Oregon
b. Participating in sports or other activities
c. Insurance coverage
d. Deciding legal rights, administrative awards or benefits, corrections or social service placement.

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

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

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

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

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

**Services Provided by Volunteer Workers**

**Taxes, Fees and Interest**
Except as required by law

**Telehealth**
Except telemedicine as specifically described in section 7.5.44. This exclusion does not apply to covered case management.

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

**Third Party Liability Claims**
Services and supplies to treat a medical condition that a third party is or may be responsible for, to the extent of any recovery received from or on behalf of the third party (see section 10.4.3)

**Transportation**
Except medically necessary ambulance transport as described in section 7.3.1

**Treatment in the Absence of Illness**
Including individual or family counseling or treatment for marital, behavioral, financial, family, occupational or religious problems, treatment for at risk individuals who do not have an illness, diagnosed mental health condition or substance use disorder, or treatment of normal transitional response to stress

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

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

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

If a service is not medically necessary to treat or diagnose your condition, it is not covered even if the condition is otherwise covered under the Plan. The fact that a professional provider may prescribe, order, recommend, or approve a service or supply does not, of itself, make the charge a covered expense.

**Vision Care**
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 where specifically covered under the Plan. See section 7.5.10 for coverage of annual dilated eye exam to manage of diabetes.

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

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

**Wigs, Toupees, Hair Transplants**

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

## 8.1 OTHER EXCLUSIONS

Notwithstanding the scope of exclusions mentioned above, the following services, procedures and conditions are not covered, even if they relate to a condition that is otherwise covered by the Plan, or if recommended, referred, or provided by a provider.

**Knee Viscosupplementation**

**Wart Removal or Treatment**
Except for plantar and sexually transmitted warts.

**Wrist Ganglion Cyst Surgery**

# SECTION 9. ELIGIBILITY AND ENROLLMENT

This section outlines who is eligible for coverage and the related enrollment procedures that apply to eligible PEBB employees and eligible dependents. Benefits are not available to anyone who is not properly enrolled in the Plan.

There will be an open enrollment period each year. The effective date of coverage of new members who enroll during the open enrollment period is the beginning of the plan year for which they enroll.

## 9.1 PEBB SUBSCRIBER ELIGIBILITY AND ENROLLMENT

PEBB employees are eligible for coverage as specified in the eligibility or coverage continuation provisions established by PEBB. The PEBB eligibility rules are governed under provisions of the Oregon Administrative Rules, Chapter 101. Employees or retirees should refer to the PEBB eligibility rules and the PEBB Summary Plan Description for detailed information on eligibility and program requirements.

## 9.2 DEPENDENT ELIGIBILITY AND ENROLLMENT

Eligible dependent means a person who is eligible for coverage by a PEBB employee as specified in the eligibility or coverage continuation provisions established by PEBB. The PEBB eligibility rules are governed under provisions of the Oregon Administrative Rules, Chapter 101. Employees or retirees should refer to the PEBB eligibility rules and the PEBB Summary Plan Description for detailed information on eligibility and program requirements.

Employees must enroll their eligible dependents in accordance with the requirements established by PEBB. No eligible dependent will become a member until PEBB approves that eligible dependent for coverage. The PEBB eligibility rules are governed under provisions of the Oregon Administrative Rules, Chapter 101. Employees or retirees should refer to the PEBB eligibility rules and the Summary Plan Description for detailed information on eligibility and program requirements.

A subscriber's newborn or adopted child who meets the definition of a PEBB eligible dependent is eligible for enrollment from the date of birth or placement for the purpose of adoption. The PEBB eligibility rules are governed under provisions of the Oregon Administrative Rules, Chapter 101. Employees or retirees should refer to the PEBB eligibility rules and the PEBB Summary Plan Description for detailed information on eligibility and program requirements.

## 9.3 SPECIAL ENROLLMENT PERIODS

If coverage is declined when initially eligible, an eligible employee or any dependent(s) may enroll in the Plan during a special enrollment period. The PEBB eligibility rules are governed under provisions of the Oregon Administrative Rules, Chapter 101. Employees or retirees should refer to the PEBB eligibility rules and the PEBB Summary Plan Description for detailed information on eligibility and program requirements.

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

## 9.4 ELIGIBILITY AUDIT

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

# SECTION 10. CLAIMS ADMINISTRATION & PAYMENT

## 10.1 SUBMISSION AND PAYMENT OF CLAIMS

What to know about sending us a claim:

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

The date of service is the date you receive the service or supply. You must actually receive the service or supply before the Plan will pay the claim. Usually, you can show your Moda Health ID card to the provider, and they will bill us for you. The Plan will pay the provider and send a copy of the payment record to you. The provider will then bill you for any charges that were not covered.

### 10.1.1 How to Send Us Claims

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

Include all of the following information:

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

Some claims will require additional information:

a. **Accidental injury**: Include the date, time, place, and description of the accident
b. **Ambulance service**: Include where you were picked up and taken
c. **Out-of-country care**: Only covered when you have an emergency or need urgent care. When you get care outside the United States, include:

    i. Explanation of where you were and why you needed care
    ii. Copy of the medical record (translated if available)

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

### 10.1.2 Prescription Medication Claims

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

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

### 10.1.3 Explanation of Benefits (EOB)

We will tell you how we processed a claim in a document called an Explanation of Benefits (EOB). The EOB will show if a claim has been paid, denied or accumulated toward satisfying the deductible. If all or part of a claim is denied, we will tell you why in the EOB. We encourage you to access your EOBs electronically by signing up through your Member Dashboard.

If you do not receive an EOB or an email telling you that an EOB is available within a few weeks of the date of service, this may mean that we did not receive the claim. Your claim will not be paid unless we receive it within the claim submission period explained in section 10.1.

### 10.1.4 Claim Inquiries

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

### 10.1.5 Time Frames for Processing Claims

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

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

We must receive all information we need to process your claim within the Plan's claim submission period explained in section 10.1.

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

### 10.1.6 Time Frames for Processing Prior Authorizations and Utilization Reviews

Any utilization review decision will be made within 2 business days after receipt of the request for prior authorization of nonemergency situations. For emergency situations, utilization review decisions for care following emergency services will be made as soon as is practicable but in any event no later than 24 hours after receiving the request for prior authorization or for coverage determination.

## 10.2 COMPLAINTS, APPEALS & EXTERNAL REVIEW

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

### 10.2.1 Time Limit for Submitting Appeals

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

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

### 10.2.2 The Review Process

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

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

**How First and Second Level Appeals Work**

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

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

**Expedited Appeals**

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

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

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

The timelines for reviewing your appeal do not apply if:

a. You do not reasonably cooperate
b. Circumstances beyond your control or ours make it impossible. Whoever is unable to meet a timeline must give notice of the specific reason to the other when the issue arises.

### 10.2.3 External Review

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

a. The request for external review must be in writing no more than 180 days after you receive the final internal adverse benefit determination. Upon receipt of your request, we will send information about your case to the IRO. You may submit additional information to the IRO within 5 days, or 24 hours for an expedited review.
b. You must have completed the appeal process described in section 10.2.2. We will send an appeal directly to external review if we both agree to skip this requirement. For an expedited appeal or when the appeal is about a condition for which you received emergency services and are still hospitalized, a request for external review may be expedited at the same time as a request for internal appeal review.
c. You shall provide complete and accurate information to the independent review organization in a timely manner.

We will notify the Oregon Division of Financial Regulation of your request for external review no later than the second business day after receipt of the request and the Plan will pay the cost of the external review. You may submit additional information to the IRO no later than 5 business days after the appointment of the review organization or 24 hours in the case of an expedited review. The IRO will complete their review within:

a. 3 days for expedited reviews (notification is immediate)
b. 30 days when not expedited (notification is within 5 days)

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

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

### 10.2.4 Complaints

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

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

c. The contractual relationship between us.

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

### 10.2.5 Additional Member Rights

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

### 10.2.6 Definitions

For purposes of section 10.2, the following definitions apply:

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

a. Rescission of coverage
b. Eligibility to participate in the Plan
c. Network exclusion, annual benefit limit or other limitation on otherwise covered services
d. Utilization review (described below)
e. Limitations or exclusions described in Section 7 or Section 8, including a decision that an item or service is experimental or investigational or not medically necessary
f. Continuity of care (section 10.3) is denied because the course of treatment is not considered active.

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

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

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

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

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

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

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

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

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

## 10.3 CONTINUITY OF CARE

Sometimes a provider's contract with the network ends. On the day a provider's contract with us ends, they become an out-of-network provider. When this happens, the Plan may cover some services by the provider as if they were still in network for a limited period of time. This is called continuity of care.

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

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

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

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

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

Continuity of care for ongoing care ends on the earlier of the following dates for most members:

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

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

a. 45 days after your baby is born
b. If you continue active treatment, not later than 120 days after the date you were told the contract with your provider had ended

Continuity of care is not available if:

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

## 10.4 BENEFITS AVAILABLE FROM OTHER SOURCES

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

### 10.4.1 Coordination of Benefits (COB)

Coordination of benefits applies when you have healthcare coverage under more than one plan. If you are covered by another plan or plans, the benefits under this Plan and the other plan(s) will be coordinated. This means one plan pays its full benefits first, and then any other plans pay. The Plan follows the order of benefit determination rules in the Oregon Administrative Rules. These rules decide which plan is primary and pays a claim for benefits first. (For coordination with Medicare, see section 10.4.2)

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

#### 10.4.1.1 When this Plan Pays First

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

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

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

#### 10.4.1.2 How COB Works

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

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

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

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

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

**10.4.1.3 Definitions**

For purposes of section 10.4.1, the following definitions apply:

**Plan** is any of the following that provides benefits or services for medical or dental care or treatment.

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

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

If separate contracts are used to provide coordinated coverage for covered persons in a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

Plan does not include:

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

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

These are not allowable expenses:

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

### 10.4.2 Coordination with Medicare

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

### 10.4.3 Third Party Liability

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

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

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

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

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

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

d. Even without your written authorization, we may release to, or obtain from, any other insurer, organization or person, any information we need to carry out the provisions of section 10.4.3.

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

f. Section 10.4.3 applies to you if the Plan advances benefits whether or not the event causing your injuries occurred before you became covered by the Plan.

If you or your representatives do not comply with the requirements of this section, then the Plan may not advance payment or may suspend payment of any benefits, or recover any benefits we have advanced, for any medical condition related to the third party claim except for claims

related to motor vehicle accidents (see section 10.4.4). We may notify medical providers seeking payment that all payments have been suspended and may not be paid.

### 10.4.4 Motor Vehicle Accident Recovery

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

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

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

## SECTION 11. CONTINUATION OF HEALTH COVERAGE

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

Continuation of coverage under the PEBB program is governed under Chapter 101, Division 30 of the Oregon Administrative Rules. The following is a summary of continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). There may be additional continuation options available; employees should refer to the PEBB Summary Plan Description for detailed information on continuation of coverage.

### 11.1 COBRA CONTINUATION COVERAGE

COBRA continuation is administered by a COBRA Administrator. The Plan Sponsor, the Public Employees' Benefit Board (PEBB) is located at 1225 Ferry Street SE in Salem, Oregon or at (503) 373-1102 or 1-800-788-0520 for more information.

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

You may elect COBRA if you are the subscriber and you lose coverage because your employment ended (other than for gross misconduct), or your hours are reduced. Be sure to look at *Special Circumstances at the end of the COBRA section.

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

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

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

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

You are responsible for all COBRA premiums. Due to the 60-day election period, you will owe retroactive premiums for the months between when regular coverage ended and the first

payment date. You must pay these premiums in a lump sum at the first payment. The first payment is due within 45 days after you elect coverage (this is the date the election notice is postmarked, if mailed, or the date the COBRA Administrator receives it, if hand-delivered). The premium rate may include a 2% add-on to cover administrative expenses.

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

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

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

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

If the Social Security Administration determines you are disabled, your 18-month COBRA period may be extended to a total of up to 29 months. The disability must have started before the 61st day of your COBRA coverage period. The Social Security Administration must make its decision before the end of your initial 18-month COBRA period. You must give a copy of the Social Security Administration's determination of disability to the COBRA Administrator no more than 60 days after the latest of:

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

Each family member on COBRA can have the disability extension if one of you qualifies. Your COBRA premiums may increase after the 18th month of coverage to 150% of the premium.

Your disability extension ends if you are no longer considered disabled.

If you are a spouse or child on COBRA and a second qualifying event occurs, your maximum COBRA period may be extended to 36 months from the date of the first qualifying event. Second qualifying events may include the death of the subscriber, divorce or legal separation from the subscriber, or a child's no longer being eligible as a dependent under the Plan. These events can be a second qualifying event only if they would have caused you to lose coverage if the first qualifying event had not occurred.

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

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

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

***Special Circumstances**
References within the COBRA section to spouse apply to a domestic partner unless otherwise stated. For divorce or legal separation, termination of domestic partnership applies for domestic partners.

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

## 11.2 WORKERS' COMPENSATION

If you have a work-related medical condition and are not working enough hours to be eligible because of it, you may continue your coverage for up to 6 months. You must have filed a workers' compensation claim. You must pay the full premiums to the Plan, on time. Your workers' compensation continuation will end early you become employed full-time with another employer.

## 11.3 STRIKE OR LOCKOUT

If you are employed under a collective bargaining agreement and involved in a work stoppage because of a strike or lockout, you must pay the full premiums, including any part usually paid by the Group, to the union or trust. The union or trust must continue to pay the Group the premiums when due.

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

a. Fewer than 75% of those normally enrolled choose to continue their coverage
b. You become employed full-time with another employer
c. You lose eligibility under the Plan for other reasons

## SECTION 12. DEFINITIONS

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

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

**Authorization** see Prior Authorization.

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

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

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

**Coinsurance** is a percentage of covered expenses that you pay. If your coinsurance is 20%, you pay 20% of the covered charge and the Plan pays the other 80%.

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

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

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

**Custodial Care** means care that helps you conduct common activities such as bathing, eating, dressing, getting in and out of bed, preparation of special diets and supervision of medication that usually can be self-administered. It is care that can be provided by people without medical or paramedical skills.

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

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

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

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

a. **Registered Domestic Partner** is a person joined with the subscriber in a partnership that has been registered in Oregon according to the Oregon Family Fairness Act.
b. **Unregistered Domestic Partner** means a person who has entered into a partnership with the subscriber that meets the criteria in the Plan's affidavit of domestic partnership and must have a PEBB Domestic Partner Affidavit on file with the Group.

**E-Visits** means a consultation for the treatment of a covered medical condition through e-mail with a PCP 360 when deemed medically necessary and appropriate by the provider and involves a significant amount of time from the PCP 360's time.

**Eligible Employee** is any employee or former employee who meets the eligibility requirements to be enrolled under the Plan (see section 9.1).

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

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

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

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

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

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

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

a. Involve a treatment for which scientific or medical assessment has not been completed, or the effectiveness of the treatment has not been generally established. This includes a treatment program that may be proven for some uses, but scientific literature does not support the use as requested or prescribed. An example is a medication that is proven as a treatment when used alone, but scientific literature does not support using it in combination with other therapies.
b. Are available in the United States only as part of clinical trial or research program for the illness or condition being treated
c. Are not provided by an accredited institution or provider within the United States or are provided by one that has not demonstrated medical proficiency in the provision of the service or supplies
d. Are not recognized by the medical community in the service area in which they are received
e. Involve a treatment for which the approval of one or more government agencies is required, but has not been obtained at the time the services and supplies are provided or are to be provided

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

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

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

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

**Implant** is a material inserted or grafted into tissue.

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

**In-Network** refers to PCP 360 providers contracted under one of our approved networks to provide care to you.

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

MPA for out-of-network services is the lesser of a supplemental provider fee arrangement we may have in place or the amount calculated using any one of the following methods: a percentage of the Medicare allowable amount, a percentage of the allowable amount established by the

Oregon Health Authority, a percentile of fees commonly charged for a given procedure in a given area, a percentage of the acquisition cost or a percentage of the billed charge.

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

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

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

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

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

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

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

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

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

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

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

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

**Mental Health Condition** is any mental health disorder covered by diagnostic categories listed in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5).

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

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

**Moda Health** refers to Moda Health Plan, Inc. Where this book refers to "we", "us" or "our" it is referring to Moda Health or its employees. Moda Health is the claims administrator of the Plan. References to Moda Health as paying claims or issuing benefits mean that Moda Health processes a claim and the Plan Sponsor reimburses Moda Health any benefit issue.

**Network** is a group of providers who contract to provide healthcare to you at negotiated rates. Covered medical expenses are paid at a higher rate when an in-network provider is used, as shown in Section 3.

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

A **PCP 360** is a high quality primary care provider willing to partner with members and be accountable for their health. PCP 360s provide higher quality care with lower out of pocket cost. Members must choose a PCP 360 (see section 5.2).

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

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

**Plan Sponsor** means the Group.

**Primary Care Physician (PCP)** is the in-network physician or women's healthcare provider you choose to be responsible for your medical care.

**Prior Authorization** or **Prior Authorized** refers to getting approval from us before the date of service. A complete list of services and medications that require prior authorization is available on your Member Dashboard or you can ask Customer Service. A service, supply or medication that is not prior authorized when required will not be covered (see Section 6).

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

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

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

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

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

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

# SECTION 13. GENERAL PROVISIONS & LEGAL NOTICES

## 13.1 MEMBER DISCLOSURES

**What are my rights and responsibilities as a Moda Health member?**

You have the right to:

a. Information about the Plan and how to use it, the providers who will care for you, and your rights and responsibilities.
b. Be treated with respect and dignity
c. Urgent and emergency services, 24 hours a day, 7 days a week
d. Participate in decision making regarding your healthcare. This includes
    i. changing to a new primary care physician (PCP 360)
    ii. a discussion of appropriate or medically necessary treatment options, no matter how much they cost or if they are covered,
    iii. the right to refuse treatment and be informed of the possible medical result
    iv. filing a statement of wishes for treatment (known as an Advanced Directive), or giving someone else the right to make healthcare choices for you when you are unable to (Power of Attorney)
e. Privacy. Personal and medical information will only be used or shared as required or allowed by state and federal law.
f. Appeal a decision or file a complaint about the Plan, and to receive a timely response.
g. Free language assistance services when communicating with us
h. Make suggestions regarding the Plan's member rights and responsibilities policy

You have the responsibility to:

a. Read this handbook and make sure you understand the Plan. You should call Customer Service if you have any questions.
b. Select a PCP 360 and tell us who you have chosen
c. To the extent required by the Plan, seek medical services only from your PCP. This includes getting approval from your PCP before going to a specialist
d. Treat all providers and their staff with courtesy and respect
e. Be on time for appointments and call the office ahead of time if you will be late or need to cancel.
f. Get regular health checkups and preventive services
g. Give their provider all the information they need to provide good healthcare to you
h. Participate in making decisions about your medical care and forming a treatment plan
i. Follow plans and instructions for care you have agreed to with your provider
j. Use urgent and emergency services appropriately
k. Show your medical ID card when seeking medical care
l. Tell providers about any other insurance policies that may provide coverage
m. Reimburse the Plan from any third party payments you may receive
n. Provide information the Plan needs to properly administer benefits and resolve any issues or concerns that may arise

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

**The Plan requires you to select a PCP 360 and for your PCP 360 to coordinate all healthcare needs. How do I know when I need a referral?**

You do not need a referral. When medically necessary, your PCP 360 will direct you to an in-network provider for specialized care or services.

**What if I have a medical emergency?**

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

You do not need to contact your PCP 360 before you get emergency treatment. You should contact your PCP 360 as soon as reasonably possible afterward. You are covered anywhere in the world for medical emergency treatment. More information is in section 7.3.

**How will I know if my benefits changed or end?**

The Group will notify you if your benefits change or your coverage is terminated.

**Will I be informed if the PCP is no longer participating in the network?**

If your PCP 360 ends their participation in the network, we will inform you and provide instructions on how to select a new PCP 360.

**If I am not satisfied with the plan, how can an appeal or a complaint be filed?**

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

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

**What are the prior authorization and utilization review criteria?**

Getting prior authorization is your assurance that the services and supplies recommended by your provider are medically necessary and covered under the Plan. Except in the case of fraud or misrepresentation, prior authorization for benefit coverage and medical necessity is binding for 60 days, and eligibility is binding for 5 business days from the date of the authorization.

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

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

**What are my rights under the Women's Health and Cancer Rights Act of 1998 (WHCRA)?**

You have benefits for mastectomy related services. This includes all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses and complications resulting from a mastectomy, including lymphedema. Contact Customer Service for more information.

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

We protect your information in several ways:

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

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

Customer Service will coordinate the services of an interpreter over the phone when they call.

**What is provider risk sharing?**

This plan includes risk sharing arrangements with PCP 360s. Under a risk-sharing arrangement, providers are subject to some financial risk or reward for the services they deliver. Contact us for more information.

## 13.2 MISCELLANEOUS PROVISIONS

**Contract Provisions**

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

**Confidentiality of Member Information**

Keeping your protected health information (PHI) confidential is very important to the Plan. PHI includes enrollment, claims, and medical and dental information. This information is used to pay your claims and authorize services. It is also used for referrals, case management and quality management programs. We do not sell your information. The Notice of Privacy Practices has more detail about how the Group uses your PHI. Moda Health, as the claims administrator, is required to follow these same practices. Members may contact the Group if they have additional

questions about the privacy of information beyond what is provided in the Notice of Privacy Practices.

**Right to Collect & Release Needed Information**

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

**Transfer of Benefits**

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

**Correction of Payments or Recovery of Benefits**

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

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

**Warranties**

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

**No Waiver**

Any waiver of any provision of the Plan or any performance under the Plan must be in writing and signed by the waiving party. Any such waiver shall not operate as, or be deemed to be, a waiver of any prior or future performance or enforcement of that provision or any other provision. If the Plan 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 the Plan's rights to enforce the provisions of the Plan.

**Group is the Agent**

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

**Responsibility for Quality of Medical Care**

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

**Compliance with Federal & State Mandates**

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

**Governing Law**

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

**Where any Legal Action Must be Filed**

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

**Time Limits for Filing a Lawsuit**

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

**Evaluation of New Technology**

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

**Replacing Another Plan**

If this Plan replaces an existing group plan, the following applies:

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

**Notices**

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

# Nondiscrimination notice

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

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

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

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

888-217-2363 (TDD/TTY 711)

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

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

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

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

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

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

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

### Dave Nesseler-Cass coordinates our nondiscrimination work:

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



moda HEALTH

DELTA DENTAL
Delta Dental of Oregon & Alaska

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

modahealth.com

moda HEALTH

DELTA DENTAL

Delta Dental of Oregon & Alaska

39969758 (9/19)


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

P.O. Box 40384
Portland, OR 97240