Oregon Group Medical Plan

OEBB
Preferred Provider Organization (PPO) plan
Plan 3

Effective Date: October 1, 2021
Group Number: 100000016

Health plans in Oregon administered by Moda Health Plan, Inc.

moda HEALTH

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SECTION 1. WELCOME

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

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

Members receive the enhanced benefits of coordinated care by choosing and using a PCP 360, see section 5.2.

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

Members may direct questions to one of the numbers listed in section 2.1 or access tools and resources on Moda Health's personalized member website, Member Dashboard, at www.modahealth.com/oebb. Member Dashboard is available 24 hours a day, 7 days a week allowing members to access plan information whenever it is convenient.

Moda Health reserves the right to monitor telephone conversations and email communications between its employees and the members for legitimate business purposes as determined by Moda Health.

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

Members may call customer service at 866-923-0409 or email OEBBQuestions@modahealth.com to request a hardcopy of this handbook free of charge.

SECTION 2. MEMBER RESOURCES

2.1 CONTACT INFORMATION

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

Includes many helpful features, such as:

- Find Care (use to find an in-network provider)
- Prescription price check tool and formulary (medication cost estimates and benefit tiers)
- Prior authorization lists (services and supplies that may require authorization) – see Referral and Authorization link under Resources

Medical Health Navigator (Customer Service) Department
866-923-0409
En Español 888-786-7461
OEBBQuestions@modahealth.com

Behavioral Health Customer Service Department
888-474-8538

Disease Management and Health Coaching
800-913-4957

Hearing Services Customer Service
TruHearing
866-202-2178

Virtual Care preferred vendor
CirrusMD
Cirrusmd.com/modahealth

Pharmacy Customer Service Department
866-923-0411

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

Prior Authorization
800-258-2037

Telecommunications Relay Service for the hearing impaired
711

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

2.2 MEMBERSHIP CARD

After enrollment, members will receive ID (identification) cards that include the group and identification numbers. Members will need to present the card each time they receive services. Members may go to the Member Dashboard or contact Customer Service to replace a lost ID card. Identification cards can be accessed via a smart phone.

2.3 NETWORKS

See Network Information (Section 5) for detail about how networks work and how to choose a PCP 360 for coordinated care benefits.

Medical network
Connexus is the primary network, see section 5.1.1 for additional networks available to retirees and COBRA members.

Pharmacy network
Navitus

Travel network
First Health

2.4 CARE COORDINATION

2.4.1 Care Coordination

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

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

2.4.2 Disease Management/Health Coaching

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

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

Contact Disease Management and Health Coaching at 1-800-913-4957 for more information.

2.4.3 Behavioral Health

Moda Behavioral Health provides specialty services for managing mental health and chemical dependency benefits to help members access effective care in the right place and contain costs. Behavioral Health Customer Service can help members locate in-network providers and understand the mental health and chemical dependency benefits.

2.5 OTHER RESOURCES

Additional member resources providing general information about the Plan can be found in Section 12 and Section 14.

SECTION 3. SCHEDULE OF BENEFITS

This section is a quick reference summarizing the Plan's benefits.

The details of the actual benefits and the conditions, limitations and exclusions of the Plan are contained in the sections that follow. Prior authorization may be required for some services (see section 6.1). An explanation of important terms is found in Section 16.

Cost sharing is the amount members pay. See Section 4 for more information, including an explanation of deductible and out-of-pocket maximum. Members must choose and use a PCP 360 to get coordinated care benefits (see section 5.2). For services provided out-of-network, members may also be responsible for any amount in excess of the maximum plan allowance.

Benefits accrue on a plan year basis beginning October 1st of each year and ending September 30th of the following year.

	In-Network Coordinated Care Benefits	**In-Network Non-coordinated Benefits**	**Out-of-Network Benefits**
Plan year deductible per member	**$1,200**	**$1,300**	**$2,400**
Maximum plan year family aggregate deductible	**$3,900**	**$3,900**	**$7,200**
Plan year out-of-pocket maximum per member (includes deductible)	**$4,850**	**$5,250**	**$10,000**
Plan year out-of-pocket maximum per family (includes deductible)	**$15,750**	**$15,750**	**$27,400**
Plan year maximum cost sharing per member (includes out-of-pocket, additional cost tier and pharmacy)	**$7,900**	**$7,900**	**No maximum**
Plan year maximum cost sharing per family (includes out-of-pocket, additional cost tier and pharmacy)	**$15,800**	**$15,800**	**No maximum**

Services	**Cost Sharing** (Deductible applies unless noted differently)		**Section in Handbook & Detail**
	In-network	**Out-of-network**	
Urgent & Emergency Care			
Ambulance Transportation	25%	25%, in-network level deductible and out-of-pocket maximum apply	Section 7.3.1

Services	Cost Sharing (Deductible applies unless noted differently)		Section in Handbook & Detail
	In-network	Out-of-network	
Emergency Room Facility (includes ancillary services)	$100 copayment per visit, then 25%	$100 copayment per visit, then 25%, In-network deductible and out-of-pocket maximum apply	Section 7.3.2 No copay if covered hospitalization immediately follows emergency room use
ER professional or ancillary services billed separately	25%	25%, in-network deductible and out-of-pocket maximum apply	
Urgent Care Office Visit			Section 7.3.3 In-network deductible and out-of-pocket maximum apply to mental health and chemical dependency services
Coordinated Care	$50 per visit, no deductible	25%	
Non-coordinated Benefits	25%	25%	
Preventive Services			
Services as required under the Affordable Care Act, including the following:	No cost sharing	50%	Section 7.4
Colonoscopy	No cost sharing	50%	Section 7.4.2
Hearing Screening	No cost sharing	50%	Section 7.4.4
Immunizations	No cost sharing	50%	Section 7.4.5
Mammogram	No cost sharing	50%	Section 7.4.11 One between the ages of 35 and 39, and one per plan year age 40+
Preventive X-ray & Lab	No cost sharing	50%	Section 7.5.11
Preventive Health Exams	No cost sharing	50%	Section 7.4.7 6 visits in first year of life 7 exams from age 1 to 4 One per year, age 5+
Tobacco Cessation Treatment			Section 7.4.9
Consultation	No cost sharing	50%	
Supplies	No cost sharing	25%	
Women's Exam & Pap Test	No cost sharing	50%	Section 7.4.11 One per year
Vision Screening	No cost sharing	50%	Section 7.4.6 Age 3 to 5
Other preventive services, including:			
Cardiovascular Screening	No cost sharing	50%	Section 7.5.11

Services	Cost Sharing (Deductible applies unless noted differently)		Section in Handbook & Detail
	In-network	Out-of-network	
Diagnostic X-ray & Lab			Section 7.5.11
At Quest Labs	No cost sharing	N/A	
All other providers	25%	50%	
Obesity Screening	No cost sharing	50%	One per plan year
Prostate Rectal Exam	No cost sharing	50%	Section 7.4.8 One per year, age 50+
Prostate Specific Antigen (PSA) Test	No cost sharing	50%	
Wellness Visit	No cost sharing	N/A	Section 7.4.10 Age 21+
Outpatient Services			
Acupuncture			Section 7.5.1
Coordinated Care	$25 per visit, no deductible	50%	Limited to 12 visits per plan year, limit includes both acupuncture and spinal manipulation
Non-coordinated Benefits	25%	50%	
Anticancer Medication	25%	50%	Section 7.5.2 May require authorization
Applied Behavior Analysis	25%	50%	Section 7.5.3
Biofeedback			Section 7.5.4 10 visit lifetime maximum
Coordinated Care	$50 per visit, no deductible	50%	
Non-coordinated Benefits	25%	50%	
Chemical Dependency Services	$25 per visit, no deductible	50%	Section 7.5.5
Coordinated Specialty Programs	No cost sharing	50%	Section 7.5.8
Dental Injury	25%	50%	Section 7.5.9
Diabetes Services	25%	50%	Section 7.5.10 Supplies covered under DME and Pharmacy benefits
Diagnostic Procedures, including x-ray and lab			Section 7.5.11
At Quest Labs	No cost sharing	N/A	
All other providers	25%	50%	

Services	Cost Sharing (Deductible applies unless noted differently)		Section in Handbook & Detail
	In-network	Out-of-network	
Infusion Therapy			Section 7.5.14
Home Infusion for chemotherapy	25%	50%	Requires authorization. Some medications may require use of authorized provider to be eligible for coverage
Home Infusion for all other infusion services	No cost sharing	50%	
Outpatient Infusion	25%	50%	Requires authorization. Some medications may require use of authorized provider to be eligible for coverage. Outpatient hospital setting not covered for some medications
Kidney Dialysis	25%	50%	Section 7.5.15
Mental Health Services	$25 per visit, no deductible	50%	Section 7.5.18
Nutritional Therapy	25%	50%	Section 7.5.19 Requires authorization after first 5 visits.
Office and Home Visits			
Incentive Care Visits (for asthma, heart conditions, cholesterol, high blood pressure, and diabetes)			Section 7.5.20
Coordinated Care PCP 360 or in-network Specialist	$20 per visit, no deductible	N/A	Members must use their chosen PCP 360 or an in-network specialist
Coordinated Care Other Provider	25%	50%	
Non-coordinated Benefits	25%	50%	
Primary Care Office Visits			Section 7.5.20
Coordinated Care PCP 360	$25 per visit, no deductible	N/A	Members must use their chosen PCP 360
Coordinated Care Other Provider	$50 per visit, no deductible	50%	
Non-coordinated Benefits	25%	50%	
Specialist Visit			Section 7.5.20
Coordinated Care	$50 per visit, no deductible	50%	
Non-coordinated Benefits	25%	50%	

Services	Cost Sharing (Deductible applies unless noted differently)		Section in Handbook & Detail
	In-network	**Out-of-network**	
Virtual Care Visits			Section 7.8.8 For primary care and urgent care office visits only
Through CirrusMD	No cost sharing	N/A	Log on via cirrusmd.com/modahealth
Other providers	$10 per visit, no deductible	50%	
Rehabilitation & Habilitation (Physical, occupational and speech therapy)	25%	50%	Section 7.5.22 30 sessions per year, except as required for mental health parity. May be eligible up to 60 sessions for head or spinal cord injury. Habilitation only covered for mental health conditions
Spinal Manipulation			Section 7.5.23
Coordinated Care	$25 per visit, no deductible	50%	Limited to 12 visits per plan year, limit includes both acupuncture and spinal manipulation
Non-coordinated Benefits	25%	50%	
Surgery and Invasive Diagnostic Procedures	25%	50%	Section 7.5.24
Temporomandibular Joint Syndrome (TMJ)	25%	50%	Section 7.5.25
Therapeutic Injections	25%	50%	Section 7.5.26
Therapeutic Radiology	25%	50%	Section 7.5.27
Inpatient & Residential Facility Care			
Chemical Dependency Detoxification	$25 per visit, no deductible	50%	Section 7.6.1
Hospital Physician Visits	25%	50%	Section 7.6.4
Inpatient Care	25%	50%	Section 7.6.3
Partial Hospital Treatment Programs for Chemical Dependency	$25 per visit, no deductible	50%	Section 7.6.8
Rehabilitation & Habilitation (Physical, occupational and speech therapy)	25%	50%	Section 7.6.7 30 days per year, except as required for mental health parity. May be eligible for up to 60 days for head or spinal cord injury. Habilitation only covered for mental health conditions

Services	Cost Sharing (Deductible applies unless noted differently)		Section in Handbook & Detail
	In-network	Out-of-network	
Residential Chemical Dependency Treatment Programs	$25 per visit, no deductible	50%	Section 7.6.8
Residential Mental Health Treatment Programs	25%	50%	Section 7.6.8
Skilled Nursing Facility Care	25%	50%	Section 7.6.9 60 days per year
Surgery	25%	50%	Section 7.6.10
Transplants			Section 7.6.13 Requires authorization
Center of Excellence facilities	25%	N/A	
Other facilities	Not covered	Not covered	
Additional Cost Tier (for certain outpatient and hospital services)			
Imaging Procedures	$100 copayment per procedure, then 25%	$100 copayment per procedure, then 50%	Section 7.2 May require authorization. No copayment if billed with a primary diagnosis of cancer
Sleep Studies	$100 copayment per study, then 25%	$100 copayment per study, then 50%	Section 7.2
Upper Endoscopy	$100 copayment per procedure, then 25%	$100 copayment per procedure, then 50%	Section 7.2
Spinal Injections	$100 copayment per procedure, then 25%	$100 copayment per procedure, then 50%	Section 7.2
Viscosupplementation	$100 copayment per procedure, then 25%	$100 copayment per procedure, then 50%	Section 7.2
Tonsillectomy	$100 copayment per procedure, then 25%	$100 copayment per procedure, then 50%	Section 7.2 Applies to members under age 18 with chronic tonsillitis or sleep apnea
Lumbar Discography	$100 copayment per procedure, then 25%	$100 copayment per procedure, then 50%	Section 7.2
Arthroscopy (knee and shoulder)	$500 copayment per procedure, then 25%	$500 copayment per procedure, then 50%	Section 7.2
Spine surgery	$500 copayment per procedure, then 25%	$500 copayment per procedure, then 50%	Section 7.2

Services	Cost Sharing (Deductible applies unless noted differently)		Section in Handbook & Detail
	In-network	Out-of-network	
Uncomplicated hernia repair	$500 copayment per procedure, then 25%	$500 copayment per procedure, then 50%	Section 7.2
Gastric Bypass (Roux-en-Y) or Gastric Sleeve			Section 7.9.1 Deductible applies Covered for members age 18 and over only Center of Excellence reference price applies (complications of a covered surgery are not subject to reference pricing)
Centers of Excellence	$500 copayment, then 25%	N/A	
All other facilities	Not covered	Not covered	
Knee/Hip Replacement	$500 copayment, then 25%	$500 copayment, then 50%	Section 7.9.2 Facility reference price applies (complications of a covered surgery are not subject to reference pricing)
Maternity Services			
Breastfeeding			Section 7.7.2
Support and Counseling	No cost sharing	50%	
Supplies	No cost sharing	No cost sharing	
Infertility			Section 7.7.8
Diagnosis and Surgery	25%	50%	
Ovulation and Intrauterine Insemination	50%	50%	$15,000 lifetime maximum
Infertility Medications	25%	50%	$10,000 lifetime maximum for infertility medications.
Maternity	25%	50%	Section 7.7
Newborn Nurse Home Visiting Program	No cost sharing	Not covered	Section 7.7.5 Visit limits apply
Other Services			
Disease Management for Pain	No cost sharing	50%	Section 7.8.1

Services	Cost Sharing (Deductible applies unless noted differently)		Section in Handbook & Detail
	In-network	Out-of-network	
Durable Medical Equipment, Supplies & Appliances	25%	50%	Section 7.8.2 Limits apply to some DME, supplies, appliances
Oral Appliance	25%	50%	Section 7.9.3 $1,800 reference price per oral appliance
Hearing Aids & Related Services			Section 7.8.3 Frequency limits apply $4,000 maximum every 4 years for members 26 and older
Exam			
Coordinated Care	$50 per visit, no deductible	50%	
Non-coordinated Benefits	25%	50%	
Other Services	10%	50%	
Home Healthcare	25%	50%	Section 7.8.4 140 visits per year
Hospice & Palliative Care			Section 7.8.5 When palliative care diagnosis is billed in the primary position
Home Care	No cost sharing	50%	
Inpatient Care	No cost sharing	50%	
Respite Care	No cost sharing	50%	
Naturopathic Services			Section 7.8.6
Naturopathic Office Visits			
Coordinated Care	$50 per visit, no deductible	50%	
Non-coordinated Benefits	25%	50%	
Naturopathic Substances	25%	50%	
Pharmacy			
Prescription Medication	A member who uses an out-of-network pharmacy must pay any amounts charged above the MPA		Section 7.10 No deductible
Retail Pharmacy			31-day supply per prescription
Value Tier	$4 per prescription	$4 per prescription	
Select Tier	$12 per prescription	$12 per prescription	

Services	Cost Sharing (Deductible applies unless noted differently)		Section in Handbook & Detail
	In-network	Out-of-network	
Preferred Tier	25% to a maximum of $75 per prescription	25% to a maximum of $75 per prescription	High-cost generic medications are excluded unless a formulary exception is requested and approved.
Nonpreferred Tier	50% to a maximum of $175 per prescription	50% to a maximum of $175 per prescription	Nonpreferred brand medications are excluded unless a formulary exception is requested and approved.
Mail Order Pharmacy			90-day supply per prescription.
Value Tier	$8 per prescription	Must use Moda-designated mail order pharmacy	
Select Tier	$24 per prescription		
Preferred Tier	25% to a maximum of $150 per prescription		High-cost generic medications are excluded unless a formulary exception is requested and approved.
Nonpreferred Tier	50% to a maximum of $450 per prescription		Nonpreferred brand medications are excluded unless a formulary exception is requested and approved.
90-Day Supply at Participating Retail Pharmacies			90-day supply per prescription available for some medications from participating retail pharmacies.
Value Tier	$12 per prescription	N/A	
Select Tier	$36 per prescription	N/A	
Preferred Tier	25% to a maximum of $225 per prescription	N/A	High-cost generic medications are excluded unless a formulary exception is requested and approved.
Nonpreferred Tier	50% to a maximum of $525 per prescription	N/A	Nonpreferred brand medications are excluded unless a formulary exception is requested and approved.

Services	Cost Sharing (Deductible applies unless noted differently)		Section in Handbook & Detail
	In-network	Out-of-network	
Specialty Pharmacy			31-day supply per prescription for most medications Prior authorization required.
Specialty Generic	$12 for 31-day supply, or $36 for 90-day supply when allowed	Must use Moda-designated specialty pharmacy	
Specialty Preferred	25% (to a maximum of $200 for 31-day supply, or $400 for 90-day supply when allowed)		
Specialty Nonpreferred	50% (to a maximum of $500 for 31-day supply, or $1,000 for 90-day supply when allowed)		Nonpreferred brand medications are excluded unless a formulary exception is requested and approved.
Anticancer Medication	No cost sharing	50%	Section 7.5.2

SECTION 4. PAYMENT & COST SHARING

4.1 DEDUCTIBLES

The Plan has a plan year deductible. The deductible amounts are shown in Section 3, and are the amount of covered expenses that are paid by members before benefits are payable by the Plan. That means the member pays the full cost of services that are subject to the deductible until they have spent the deductible amount. Then the Plan begins sharing costs with the member. In-network and out-of-network amounts accumulate separately. The deductible is lower when using in-network providers and lowest for members who choose and use a PCP 360 and receive coordinated care. After the deductible has been satisfied, benefits will be paid according to Section 3. When a per member deductible is met, benefits for that member will be paid according to Section 3. If coverage is for more than one member, the per member deductible applies only until the total family deductible is reached.

Disallowed charges, copayments, prescription drug out-of-pocket expenses, and manufacturer discounts and/or copay assistance programs do not apply to the plan year deductible.

Deductibles are accumulated on a plan year basis.

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

4.2 PLAN YEAR MAXIMUM OUT-OF-POCKET

The Plan has a per member and per family plan year maximum out-of-pocket for in-network and out-of-network medical expenses. Members' cost sharing, including deductibles, for covered medical services and supplies applies to the maximum out-of-pocket. After the plan year per member or per family maximum out-of-pocket is met, the Plan will pay 100% of covered services and supplies for the rest of the plan year. If coverage is for more than one member, the per member maximum out-of-pocket applies only until the total family maximum out-of-pocket is reached. The in-network and out-of-network maximum out-of-pocket accumulate separately and are not combined. Members' cost sharing for pharmacy benefits in Section 7.10 does not apply to the maximum out-of-pocket.

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

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

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

a. Pharmacy prescription expenses
b. The out-of-pocket expenses for bariatric surgery not performed at a Center of Excellence facility, or out-of-pocket expenses above the Center of Excellence reference price
c. The out-of-pocket expense for an oral appliance above the $1,800 reference price per appliance

d. The out-of-pocket expenses for a hip or knee replacement above the reference price
e. The out-of-pocket expenses for infertility treatment
f. Additional cost tier copayment
g. Disallowed charges

4.3 MAXIMUM COST SHARE

The maximum cost share includes additional cost tier copayments, pharmacy copayments and coinsurance as well as the eligible medical expenses that accrue toward the in-network maximum out-of-pocket. After the per member or per family maximum cost sharing is met, the Plan will pay 100% of covered in-network services for the rest of the plan year. If coverage is for more than one member, the per member maximum applies only until the total family maximum cost share is reached. 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.

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

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

a. Services in excess of any maximum
b. Fees in excess of maximum plan allowance
c. Premiums
d. Expenses that apply to the out-of-network maximum out-of-pocket
e. Expenses incurred due to brand substitution
f. Disallowed charges

4.4 PAYMENT

Expenses allowed by Moda Health, as administrator of the Plan, are based upon the maximum plan allowance (MPA), which is defined in Section 16. Depending upon the Plan provisions, cost sharing may apply.

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

4.5 EXTRA-CONTRACTUAL SERVICES

Extra-contractual services are services or supplies that are not otherwise covered, but which Moda Health believes to be medically necessary, cost effective and beneficial for quality of care. Moda health works with members and their professional providers to consider effective alternatives to hospitalization and other care to make more efficient use of the Plan's benefits.

After case management evaluation and analysis by Moda Health, extra-contractual services will be covered when agreed upon by a member and their professional provider and Moda Health. Any party can provide notification in writing and terminate such services.

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

SECTION 5. NETWORK INFORMATION

In-network benefits apply to services delivered by in-network providers. Out-of-network benefits apply to services delivered by out-of-network providers. By using an in-network provider, members will receive quality healthcare and will have a higher level of benefits. Members who choose coordinated care will receive the highest level of benefits.

Services a member receives in an in-network facility may be provided by physicians, anesthesiologists, radiologists or other professionals who are out-of-network providers. When a member receives services from these out-of-network providers, any amounts charged above the MPA could be the member's responsibility (see section 5.1.4).

5.1 GENERAL NETWORK INFORMATION

5.1.1 Primary Network; Primary Service Area

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

Members should ask if their provider (both professional provider and facility) is participating with the specific network listed below. Do not ask if the provider accepts Moda. There are many Moda Health networks. A provider may participate in some Moda Health networks, but not in the network for this Plan. Members may contact Customer Service for help finding an in-network provider.

Networks

For all members:

- Connexus is available to residents of Oregon, the Idaho counties that border with Oregon, southwest Washington and northern California
- Pharmacy network is Navitus

For retirees and COBRA members residing outside the Connexus service area:

- First Choice Health (FCH) for residents of Washington (excluding southwest Washington) and Montana
- Private HealthCare systems (PHCS) is available to residents of all other states

Only retirees and COBRA members may access the networks listed above and receive the in-network level of benefits if the subscriber resides outside the Connexus service area. Subscribers and their dependents who reside in the Connexus service area will receive out-of-network benefits when using any of the other networks listed above.

For more information about these networks or how to find in-network providers, please contact:

Medical Customer Service Department
866-923-0409
Email: OEBBquestions@modahealth.com

5.1.2 Coverage Outside the Service Area for Dependents

Enrolled dependents residing outside the primary service area may receive in-network benefits by using a travel network provider as described in section 5.1.3. If a travel network provider is not available, plan benefits will be extended to such dependents as if the care were rendered by in-network providers, subject to the following limitations:

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

In-network benefits are not available to a dependent living outside the service area for the purpose of receiving treatment or benefits.

When an enrolled dependent moves outside the service area, members must contact Customer Service and their employer to update the dependent's address in the myOEBB system. The enrolled dependent will be eligible for out-of-area coverage the first day of the month following the date the address is updated in myOEBB.

5.1.3 Travel Network

Members traveling outside of the primary service area may receive in-network benefits by using a travel network provider for urgent or emergency services. The in-network benefit level only applies to a travel network provider if members are outside the primary service area and the travel is not for purposes of receiving treatment or benefits. The travel network is not available to members whose assigned network provides nationwide access.

Travel Network
First Health

Members may find a travel network provider by using Find Care on the Member Dashboard or by contacting Customer Service for assistance.

5.1.4 Out-of-Network Care

When members choose healthcare providers that are not in-network, the benefit from the Plan is lower, at the out-of-network level described in Section 3. In most cases the member must pay the provider all charges at the time of treatment, and then file a claim to be reimbursed the out-of-network benefit. If the provider's charges are more than the maximum plan allowance, the member may be responsible for paying those excess charges.

When receiving care at an in-network facility, ask to have ancillary services (such as diagnostic testing, anesthesia, surgical assistants) performed by in-network providers. When the member is at an in-network facility and is not able to choose the provider, in-network cost sharing will apply to services by out-of-network providers, and an Oregon-licensed provider cannot balance bill the member except when permitted by law.

5.1.5 Care after Normal Office Hours

In-network professional providers have an on-call system to provide 24-hour service. Members who need to contact their professional provider after normal office hours should call the provider's regular office number.

5.2 COORDINATED CARE AND PCP 360

To receive the enhanced benefits of coordinated care a member must choose and use an in-network PCP 360. A directory of in-network PCP 360s can be found on Member Dashboard under Find Care or by contacting Customer Service for help. Each member may choose a different PCP 360, such as a family or general practitioner, a pediatrician or a women's healthcare provider. Members can change their PCP 360 in Member Dashboard or by calling Customer Service.

If a member does not choose a PCP 360, in-network claims will be paid at the non-coordinated benefit level.

Members who did not choose a PCP 360 at the time of enrollment may choose a PCP 360 in Member Dashboard or by calling Customer Service at a later time. They will receive the enhanced benefits of coordinated care when they use their PCP 360 to coordinate their care.

A new PCP 360 may be effective as early as the first day of the month in which the member has made the change. A new PCP 360 may affect the cost sharing for services received earlier that month.

If members stop seeing their PCP 360s, they will be moved to the non-coordinated care benefit level. If this happens, they will stop receiving enhanced benefits.

If a PCP 360 no longer participates in the network, members will receive notice to choose a new PCP 360. If they do not choose and use a new PCP 360, they will be moved to the non-coordinated care benefit level and not receive enhanced benefits.

5.3 USING FIND CARE

To search for in-network providers, members can log in to their Member Dashboard account at modahealth.com/oebb 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

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 360. These providers will have a PCP 360 badge icon next to their contact information.

5.3.2 DME Providers

Find a preferred DME provider:

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

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

SECTION 6. PRIOR AUTHORIZATION

Prior authorization is used to ensure member safety, encourage appropriate use of services and medications, and support cost effective treatment options for members. Moda Health may require using a preferred treatment center or provider for the treatment to be covered. Services requiring prior authorization are evaluated using evidence based criteria that align with medical literature, best practice clinical guidelines and guidance from the FDA. Moda Health will authorize medically necessary services, supplies or medications based upon the member's medical condition. Treatments are covered only when there is medical evidence of need.

When a professional provider suggests a type of service requiring authorization (see section 6.1.1), the member should ask the provider to contact Moda Health for prior authorization. Authorization for emergency hospital admissions must be obtained by calling Moda Health within 48 hours of the hospital admission (or as soon as reasonably possible). The hospital, professional provider and member are notified of the outcome of the authorization process by letter. Prior authorization does not guarantee coverage. When a service is otherwise excluded from benefits, charges will be denied.

6.1 PRIOR AUTHORIZATION REQUIREMENTS

Members using an out-of-network provider are responsible for making sure their provider contacts Moda Health for prior authorization. Services not authorized in advance will be denied, and the full charge will be the member's responsibility.

Any amounts that are member responsibility due to not obtaining a prior authorization do not apply toward the Plan's deductible, out-of-pocket maximum or maximum cost share.

In-network providers are responsible for obtaining prior authorization on the member's behalf. If the in-network provider does not do so, they are expected to write off the full charge of the service.

Prior authorization is not required for an emergency admission.

Authorization may be considered after services are received for medications purchased at the pharmacy.

6.1.1 Services Requiring Prior Authorization

Many services within the following categories may require prior authorization:

a. Inpatient services and residential programs
b. Outpatient services
c. Rehabilitation (physical, occupational, speech therapy)
d. Imaging services
e. Infusion therapy
f. Coordinated specialty programs
g. Disease management for pain
h. Medications

A full list of services and supplies requiring prior authorization is on the Moda Health website. This list is updated periodically, and members should ask their provider to check to see if a service or supply requires authorization. A member may obtain authorization information by contacting Customer Service. For mental health or chemical dependency 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 include:

a. An authorization is valid for a set period of time. Authorized services received 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. The member may have to receive 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 the provider and member. Members who are working with a Care Coordinator or Case Manager (see section 2.4) can also get help understanding how to access their authorized treatment from their Care Coordinator or Case Manager.

6.1.3 Second Opinion

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

SECTION 7. BENEFIT DESCRIPTION

The Plan covers services and supplies listed when medically necessary for diagnosis and/or treatment of a medical condition, as well as certain preventive services. The details of the different types of benefits and the conditions, limitations and exclusions are described in the sections that follow. An explanation of important terms is found in Section 16.

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 require prior authorization. A complete list is available on the Member Dashboard or by contacting Customer Service. Sometimes the authorization will require the member to use a certain provider for the service.Failure to obtain required prior authorization or to use the authorized provider when required will result in denial of benefits (see section 6.1).

7.1 WHEN BENEFITS ARE AVAILABLE

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

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

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

7.2 ADDITIONAL COST TIER

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

$100 cost tier:

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

$500 cost tier:

a. Arthroscopy (knee and shoulder)
b. Spine surgery

c. Uncomplicated hernia repair
d. Knee / Hip Replacement (see section 7.9.2 for additional information including limitations)

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

7.3 URGENT & EMERGENCY CARE

7.3.1 Ambulance Transportation

Ambulance transportation, including local ground transportation by state certified ambulance and certified air ambulance transportation, is covered for medically necessary transport to the nearest facility that has the capability to provide the necessary treatment. Out-of-network providers may bill members for charges in excess of the maximum plan allowance.

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

7.3.2 Emergency Room Care

Members are covered for treatment of emergency medical conditions (as defined in Section 16) worldwide. A member who believes they have a medical emergency should call 911 or seek care from the nearest appropriate provider.

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

All claims for emergency services (as defined in Section 16) will be paid at the in-network benefit level. At an out-of-network emergency room, providers may bill members for charges in excess of the maximum plan allowance. Using an in-network emergency room does not guarantee that all providers working in the emergency room and/or hospital are in-network providers (see section 5.1.4 for more information).

If a covered hospitalization immediately follows emergency services, emergency room facility copayments will be waived. All other applicable cost sharing remains in effect.

Prior authorization is not required for emergency medical screening exams or treatment to stabilize an emergency medical condition, whether in-network or out-of-network.

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

The in-network benefit level is not available for out-of-network care other than emergency medical care. The following are examples of services that are not emergency medical conditions and members should not go to an emergency room for such services:

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

7.3.3 Urgent Care

Immediate, short-term medical care provided by an urgent or immediate care facility for minor but urgent medical conditions that do not pose a significant threat to life or health at the time the services are rendered is covered. The member must be actually examined by a professional provider.

7.4 PREVENTIVE SERVICES

As required under the Affordable Care Act (ACA), certain services will be covered at no cost to the member when performed by an in-network provider (see Section 3 for benefit level when services are provided out-of-network). Moda Health will use reasonable medical management techniques to determine coverage limitations where permitted by the ACA. This means that some alternatives in the services below may be subject to member cost sharing:

a. Evidence-based services rated A or B by the United States Preventive Services Taskforce (www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/) and including women's preventive services as of January 1, 2017
b. Immunizations recommended by the Advisory Committee on Immunization Practices of the Center for Disease Control and Prevention (ACIP)(www.cdc.gov/vaccines/acip/recs/)
c. Preventive care and screenings recommended by the Health Resources and Services Administration (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, 2017

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

Members may call Customer Service to verify if a preventive service is covered at no cost sharing or visit the Moda Health website for a list of preventive services covered at no cost sharing as required by the ACA. Other preventive services are subject to the applicable cost sharing when not prohibited by federal law.

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

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

7.4.1 Cardiovascular Screening

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

7.4.2 Colorectal Cancer Screening

The following services, including related charges, when recommended by the treating professional provider:

a. Routine flexible sigmoidoscopy and pre-surgical exam or consultation
b. Routine colonoscopy, including polyp removal, and pre-surgical exam or consultation
c. Double contrast barium enema
d. Fecal DNA test
e. Fecal occult blood test

Laboratory tests are covered at the medical benefit level. Colorectal cancer screening is covered at the medical benefit level if it is not performed for preventive purposes (e.g., screening for diagnostic reasons or to check symptoms). If the member has a positive result on a fecal occult blood test covered under the preventive benefit, a follow-up colonoscopy will be covered under the preventive benefit.

General anesthesia is covered at the benefit level of the related colorectal cancer screening if medically necessary. Otherwise, it is not covered.

7.4.3 Contraception

All FDA approved contraceptive methods and counseling are covered. When delivered by an in-network provider and using the most cost effective option (e.g., generic instead of brand name), contraception will be covered with no cost sharing. If there is not an in-network provider available within a reasonable distance to provide cost-effective contraceptive services timely, members must contact Customer Service for services to be authorized at no cost sharing with an out-of-network provider. If the cost effective contraception is deemed medically inadvisable by the member's provider, the Plan will cover an alternative prescribed by the provider. Over the counter contraceptives are covered under the Pharmacy benefit (section 7.10).

7.4.4 Hearing Evaluation

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

7.4.5 Immunizations

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

7.4.6 Pediatric Screenings

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

7.4.7 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 above: One exam every plan year

A preventive exam is a scheduled medical evaluation of a member 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 of appropriate immunizations, screening laboratory tests and other diagnostic procedures.

Routine diagnostic x-ray and lab work related to a preventive health exam that is not required by the ACA is subject to the standard cost sharing.

7.4.8 Routine Prostate Rectal Exam & Prostate Specific Antigen (PSA) Test

For members age 50 and over, the Plan covers one rectal examination and one PSA test every year or as determined by the treating professional provider. For members younger than 50 years of age who are at high risk for prostate cancer, including African-American members and members with a family medical history of prostate cancer, prostate rectal exam and PSA test are covered as determined by the treating professional provider.

7.4.9 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. Members may have more success with a coordinated program. Look for Moda Health's partner tobacco cessation program in Member Dashboard under the myHealth tab, or contact Customer Service.

7.4.10 Wellness Visit

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

7.4.11 Women's Healthcare

One preventive women's healthcare visit per plan year, including pelvic and breast exams and a Pap test. Breast exams are limited to women 18 years of age and older. Mammograms are limited to one between the ages of 35 and 39, and one per plan year age 40 and older.

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

Preventive screening, genetic counseling and genetic testing for breast cancer (BRCA) is covered with no cost sharing. Prior authorization is required for genetic testing.

7.5 OUTPATIENT SERVICES

Many outpatient services require prior authorization see section 6.1.1). All services must be medically necessary.

7.5.1 Acupuncture
Benefits are limited to a plan year visit limit, which includes spinal manipulation services. Other services, 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 provided.

7.5.2 Anticancer Medication
Prescribed anticancer medications, including oral, intravenous (IV) or injected medications, are covered. Most anticancer medications may require prior authorization and be subject to specific benefit limitations. Specialty anticancer medications require delivery by a Moda-designated specialty pharmacy (see section 7.10.8). For some anticancer medications, members may be required to enroll in programs to ensure proper medication use and/or reduce the cost of the medication. More information is available on the Member Dashboard or by contacting Customer Service.

7.5.3 Applied Behavior Analysis (ABA)
ABA for autism spectrum disorder and the management of care provided in the member's home, a licensed health care facility or other setting as approved by Moda Health, is covered. Services must be medically necessary and prior authorized and the provider must submit an individualized treatment plan.

Coverage for applied behavior analysis does not include:

a. Services provided by a family or household member
b. Custodial or respite care, equine assisted therapy, creative arts therapy, wilderness or adventure camps, 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, other than employee benefit plans offered by the Department and the Authority

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

7.5.5 Chemical Dependency Services
Services for assessment and treatment of chemical dependency in an outpatient treatment program that meets the definitions in the Plan (see Section 16) are covered.

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

7.5.7 Clinical Trials
Usual care costs for the care of a member who is enrolled in or participating in an approved clinical trial (as defined in Section 16) are covered. Usual care costs mean medically necessary conventional care, items or services covered by the Plan if typically provided absent a clinical trial. Such costs will be subject to the same cost sharing that would apply if provided in the absence of a clinical trial.

The Plan does not cover items or services:

a. That are not covered by the Plan if provided 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 solely for the provision or clinically appropriate monitoring of the drug, device or service being tested in the clinical trial
c. Provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the member
d. Customarily provided by a clinical trial sponsor free of charge to any person participating in the clinical trial

Participation in a clinical trial must be prior authorized by Moda Health.

7.5.8 Coordinated Specialty Programs

Mental health care that meets the Plan definition of Coordinated Specialty Program (see Section 16) is covered. These programs provide multidisciplinary, team-based care to individuals with mental health conditions and their families. Treatment must be authorized. When prior authorization cannot be obtained, providers should notify Moda Health as soon after admission as possible.

7.5.9 Dental Injury

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

a. The accidental injury must have been caused by a foreign object or was caused by acute trauma (e.g., a broken tooth resulting from biting or chewing food is not an accidental injury)
b. Diagnosis is made within 6 months of the date of injury
c. Treatment is completed within 12 months of the date of injury
d. Treatment is medically necessary and is provided by a physician or dentist while the member is enrolled in the Plan
e. Treatment is limited to that which will restore teeth to a functional state

If a member chooses to have tooth implant placement as the restoration choice following a covered dental accident, the benefit is limited to the allowed amount for a crown, bridge, or partial over the implant. Removal of tooth implants or attachments to tooth implants are not covered.

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, glucometers and test strips are covered under the pharmacy benefit (section 7.10), when purchased from a pharmacy with a valid prescription and using a preferred manufacturer (see the preferred drug list on the Member Dashboard). Pumps and other supplies may be covered under the DME benefit (section 7.8.2) when billed by a doctor.

Covered medical services for diabetes screening and management include:

a. HbA1c lab test
b. Checking for kidney disease
c. Annual dilated eye exam or retinal imaging, including one performed by an optometrist or ophthalmologist
d. Diabetes self-management programs
    i. One diabetes assessment and training program after diagnosis
    ii. Up to 3 hours of assessment and training following a change of condition, medication or treatment, when provided by a program or provider with expertise in diabetes
e. Dietary or nutritional therapy
f. Routine foot care when medically necessary

Telemedicine or virtual care visits (section 7.8.8) in connection with covered treatment of diabetes can be delivered via audio, video conferencing, Voice over Internet Protocol, or transmission of telemetry. One of the participants must be an academic health center.

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

The Plan covers diagnostic services, including x-rays and laboratory tests, psychological and neuropsychological testing, and other diagnostic procedures related to treatment of a medical or mental health condition. Members receiving treatment through Quest Labs will have both deductible and coinsurance waived. Some of these procedures may need to be prior authorized.

The Plan covers all standard imaging procedures when medically necessary and related to treatment of a medical condition. Most advanced imaging services require prior authorization (see Section 6), including radiology (such as MR procedures including MRI and MRA, CT, PET and nuclear medicine) and cardiac imaging.

A full list of diagnostic procedures that must be prior authorized is available on the Moda Health website or by contacting Customer Service.

7.5.12 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 7.5.24):
   i. Breast/chest surgery
   ii. Gonadectomy (hysterectomy/oophorectomy or orchiectomy)
   iii. Reconstruction of the genitalia
   iv. Gender confirming facial surgery by a preferred provider
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. Nose implants
f. Lip reduction
g. Collagen injections
h. Reversal, revision, or removal of gender reassignment surgery
i. Make up evaluation
j. Legal expenses related to name change
k. Travel and lodging expenses

7.5.13 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.

7.5.14 Infusion Therapy

Infusion therapy services and supplies are covered when prior authorized and ordered by a professional provider as a part of an infusion therapy regimen. For some medications, authorization may be limited to preferred medication suppliers, home infusion providers or provider office infusion only. When authorization is limited to a certain supplier, provider or setting, medications obtained from other suppliers or infusion therapy administered at a hospital outpatient facility or other in-network provider may not be covered.

Home infusion therapy must be provided by an accredited home infusion therapy agency. Members receiving treatment, for services other than chemotherapy, will have both deductible and coinsurance waived. See section 7.10.8 for self-administered infusion therapy.

Infusion therapy benefits are limited to the following:

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

In addition, covered expenses include only the following medically necessary services and supplies. Some services and supplies are not covered if they are billed separately. They are considered included in the cost of other billed charges.

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 associated with
    i. patient and/or alternative care giver training
    ii. visits necessary to monitor intravenous therapy regimen
    iii. emergency services
    iv. administration of therapy
f. collection, analysis, and reporting of the results of laboratory testing services required to monitor response to therapy

Additional information about the Plan's preferred home infusion providers, including a complete list of services and medications that require prior authorization, is available on Member Dashboard or by contacting Customer Service.

7.5.15 Kidney Dialysis

Covered expenses include:

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

7.5.16 Maxillofacial Prosthetic Services

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

7.5.17 Medication Administered by Provider, Infusion Center or Treatment Center

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

Some medications may not be covered unless they are obtained from a preferred medication supplier.

For some medications, members must 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).

See section 7.5.14 for more information about infusion therapy and prior authorization requirements. Self-administered medications are not covered under this benefit (see section 7.10.8). See section 7.10 for pharmacy benefits.

7.5.18 Mental Health

The Plan covers the following medically necessary services by a mental health provider:

a. Office or home visits, including psychotherapy
b. Intensive outpatient program
c. Case management, skills training, wrap-around services and crisis intervention
d. Coordinated specialty program
e. Transcranial magnetic stimulation (TMS) and electroconvulsive therapy

Intensive outpatient treatment and TMS require prior authorization. Coordinated specialty programs must be prior authorized or authorized as soon a reasonably possible after being started. See Section 16 for definitions. See section 7.5.11 for coverage of diagnostic services.

7.5.19 Nutritional Therapy

Nutritional therapy for eating disorders is covered when medically necessary. Authorization is required after the first 5 visits. Preventive nutritional therapy that may be 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 7.5.13).

7.5.20 Office or Home Visits

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

7.5.21 Podiatry Services

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

7.5.22 Rehabilitation & Habilitation

Rehabilitative services are physical, occupational or speech therapies provided by a licensed physical, occupational or speech therapist, physician, chiropractor or other professional provider licensed to provide such services. They are necessary to restore or improve lost function caused by a medical condition.

Rehabilitative services are subject to a plan year limit, which may be increased if the services are required following acute head or spinal cord injury when the criteria for additional services are met. To receive this additional benefit, prior authorization must be obtained before the initial

sessions have been exhausted. A session is one visit. No more than one session of each type of physical, occupational or speech therapy is covered in one day. Medically necessary outpatient services for mental health and chemical dependency are not subject to these limits.

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

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

7.5.23 Spinal Manipulation

Benefits are limited to a plan year visit limit, which includes acupuncture services. 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.

7.5.24 Surgery

Operating rooms and recovery rooms, surgical supplies and other services ordinarily provided by a hospital or surgical center are covered.

Certain surgical procedures are covered only when performed as outpatient surgery. Members should ask their professional provider if this applies to a proposed surgery, or contact Customer Service. See sections 7.6.11 and 7.6.12 for more information about cosmetic and reconstructive surgery.

7.5.25 Temporomandibular Joint Syndrome (TMJ)

Surgical procedures and splints to treat TMJ must be prior authorized. They are covered only when medically necessary because of problems including pain and/or not being able to chew properly, or in cases involving severe acute trauma. Treatment of related dental diseases or injuries is not covered.

7.5.26 Therapeutic Injections

Administrative services for therapeutic injections, such as allergy shots, are covered when given in a professional provider's office. When comparable results can be obtained safely with self-administered medications at home, the administrative services for therapeutic injections by the provider are not covered. Vitamin and mineral injections are not covered unless they are medically necessary to treat of a specific medical condition. More information is in sections 7.5.17 and 7.10.8.

7.5.27 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

7.6 INPATIENT & RESIDENTIAL FACILITY CARE

Facility care will only by covered when it is medically necessary.

A hospital is a facility that is licensed to provide inpatient and outpatient surgical, medical and psychiatric care to members who are acutely ill. Services must be under the supervision of licensed physicians and includes 24-hour-a-day nursing service by licensed registered nurses.

Hospitalization must be directed by a physician and must be medically necessary. All inpatient and residential stays require prior authorization (see Section 6). Failure to obtain required prior authorization will result in denial of benefits.

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

7.6.1 Chemical Dependency Detoxification Program

Room and treatment services by a state-licensed treatment program are covered.

7.6.2 Diagnostic Procedures

The Plan covers diagnostic services, including x-rays and laboratory tests, standard and advanced imaging procedures, psychological and neuropsychological testing, and other diagnostic procedures related to treatment of a medical or mental health condition. Members receiving treatment through Quest Labs will have both deductible and coinsurance waived.

7.6.3 Hospital Benefits

Covered expenses for hospital care are:

a. **Hospital room.** The actual daily charge
b. **Isolation care.** When it is medically necessary to protect a member from contracting the illness of another person or to protect other patients from contracting the illness of a member
c. **Intensive care unit**. Whether a unit in a particular hospital qualifies as an intensive care unit is determined using generally recognized standards
d. **Facility charges.** For surgery performed in a hospital outpatient department
e. **Other hospital services and supplies.** When medically necessary for treatment and ordinarily furnished by a hospital
f. **Take-home prescription drugs.** Limited to a 3-day supply at the same benefit level as for hospitalization

7.6.4 Hospital Visits

A visit means the member is actually examined by a professional provider. Covered expenses include consultations with written reports and second opinion consultations.

7.6.5 Medication Administered at a Preferred Treatment Center

For some medications, members must 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).

7.6.6 Pre-admission Testing

Medically necessary pre-admission testing is covered when ordered by the physician.

7.6.7 Rehabilitative & Habilitative Care

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

Covered rehabilitative care expenses are subject to a plan year limit for inpatient services delivered in a hospital or other inpatient facility that specializes in such care. Additional days may be available for treatment needed after an acute head or spinal cord injury, subject to medical necessity and prior authorization. Medically necessary services for mental health and chemical dependency are not subject to these limits.

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

7.6.8 Residential Mental Health & Chemical Dependency Treatment Programs

Room and treatment services, including partial hospitalization, by a treatment program that meets the definitions in the Plan (see Section 16) are covered.

7.6.9 Skilled Nursing Facility Care

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

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

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

Exclusions

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

a. Senile deterioration
b. Alzheimer's disease
c. Mental health condition

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

7.6.10 Surgery

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

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

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

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

7.6.11 Surgery, Cosmetic & Reconstructive

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

Cosmetic surgery is not covered. All reconstructive procedures, including surgical, dental and orthodontic repair of congenital deformities, must be medically necessary and prior authorized or benefits will not be paid. Reconstructive procedures that are partially cosmetic in nature may be covered if the procedure is medically necessary. This includes services to treat a covered mental health condition, such as gender dysphoria.

Treatment for complications related to a surgery performed to correct a functional disorder is covered when medically necessary. Treatment for complications related to a surgery that does not correct a functional disorder is not covered, except for stabilization of emergency medical conditions.

Surgery for breast augmentation, achieving breast symmetry, and replacing breast implants (prosthetics) to accomplish an alteration in breast contour or size are not covered except as provided in sections 7.5.12 and 7.6.12.

7.6.12 Surgery, Reconstructive Following a Mastectomy

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

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

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

7.6.13 Transplants

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

Definitions

Center of Excellence is a facility and/or team of professional providers with which Moda Health has contracted and arranged 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 means the covered expense of removing the tissue from the donor's body and preserving or transporting it to the site where the transplant is performed. It includes any other necessary charges directly related to locating and procuring the organ.

Transplant means a procedure or series of procedures by which:

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

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

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

Covered Benefits. Benefits for transplants are limited as follows:

a. Transplant procedures must be performed at a Center of Excellence. If a Center of Excellence cannot provide the necessary type of transplant, Moda Health will prior authorize services at an alternative transplant facility.
b. Donor costs are covered as follows:
    i. If the recipient or self-donor is enrolled in the Plan, donor costs related to a covered transplant, including expenses for an enrolled donor resulting from complications and unforeseen effects of the donation, are covered.
    ii. If the donor is enrolled in the Plan and the recipient is not, 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. Professional provider transplant services are paid according to the benefits for professional providers.
d. Immunosuppressive drugs provided during a hospital stay are paid as a medical supply. Outpatient oral and self-injectable prescription medications for transplant related services are paid under the Pharmacy Prescription benefit (section 7.10).
e. 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.

7.7 MATERNITY CARE

Pregnancy care, childbirth and related conditions are covered when rendered by a professional provider. Professional providers do not include midwives unless they are licensed and certified.

Maternity services are 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.

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

7.7.1 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.

7.7.2 Breastfeeding Support

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

7.7.3 Circumcision

Circumcision for a newborn is covered when performed within 3 months of birth and may be performed without prior authorization. A circumcision beyond age 3 months must be medically necessary and requires prior authorization.

7.7.4 Diagnostic Procedures

The Plan covers diagnostic services, including laboratory tests and ultrasounds, related to maternity care.

A full list of diagnostic services requiring prior authorization is available on the Moda Health website or by contacting Customer Service.

7.7.5 Newborn Nurse Home Visiting Program

Members must use a certified home visiting services provider for services to be covered. Certified home visiting services providers may not be available in all counties. Services include:

a. One comprehensive newborn nurse home visit within 2 to 12 weeks of birth
b. A support home visit within 2 weeks of birth and before the comprehensive visit if the family has immediate needs after the birth
c. Support telephone calls after the comprehensive home visit
d. One or 2 support home visits based on the clinical assessment of the comprehensive home visit
e. A follow-up phone call after the last services provided

Comprehensive newborn nurse home visits are provided in the family's home and support home visits are provided either in the family's home or by telehealth. This program ends by age 6 months.

7.7.6 Office, Home or Hospital Visits

A visit means the member is actually examined by a professional provider. In addition to pregnancy are and childbirth visits, nurse home visiting services are covered (see section 7.7.5).

7.7.7 Hospital Benefits

Covered hospital maternity care expenses consist of the following:

a. **Hospital room.** The actual daily charge
b. **Facility charges.** When provided at a covered facility, including a birthing center
c. **Nursery care.** While the member is confined in the hospital and receiving maternity benefits. The deductible is waived for routine nursery care.
d. **Nursery visits.** One in-nursery well-newborn infant preventive health exam is covered at no cost sharing when performed in-network. Additional visits are covered at the hospital visit benefit level.
e. **Other hospital services and supplies.** When medically necessary for treatment and ordinarily furnished by a hospital
f. **Take-home prescription drugs.** 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 in connection with childbirth will not be restricted to less than 48 hours following a normal vaginal delivery or 96 hours following a cesarean section, unless the mother's or newborn's attending professional provider, after consulting with the mother, chooses to discharge the mother or newborn earlier. Prior authorization is not required for a length of stay up to these limits.

7.7.8 Infertility Services

The Plan will cover the diagnosis and treatment of the underlying cause of infertility. The Plan will also cover services and supplies up to a lifetime maximum of $10,000 for pharmacy services and $15,000 for ovulation induction and intrauterine insemination services. This is not a combined maximum.

This benefit does not include reversal of voluntary sterilization, donor compensation for time and efforts, freezing or storage of eggs or sperms when the member does not have a cancer diagnosis, in-vitro fertilization and other advanced reproductive services, or services for unenrolled surrogate mothers.

While in-vitro fertilization is not covered, services for the removal and preservation of oocytes and sperm are covered when there is a diagnosis of cancer and the services are provided prior to the treatment of cancer. These services are also subject to the reproductive services lifetime maximum.

Infertility, as defined by **1 or more** of the following:

a. Failure to conceive after regular unprotected sexual intercourse for 1 year or more for female 35 years or younger

b. Failure to conceive after regular unprotected sexual intercourse for 6 months or more for female older than 35 years
c. Prior failed cycle of artificial insemination with the absence of an opposite-sex partner
d. Female with cancer chemotherapy-induced ovulatory failure (e.g., from cyclophosphamide)
e. Female with impending infertility due to planned cancer treatment for cure (e.g., chemotherapy or oophorectomy)
f. Female with history of bilateral oophorectomy
g. Male partner with infertility due to cancer therapy (e.g., orchiectomy or chemotherapy)
h. Male partner with non-obstructive azoospermia or severe oligospermia
i. Male partner with paraplegia and sperm retrieval needed to achieve pregnancy
j. Male partner is HIV positive and **ALL** of the following:

    i. Adherent with highly active antiretroviral therapy
    ii. Washed sperm needed for insemination to prevent HIV transmission to female partner

Prior authorization is required for infertility treatment. Some infertility medications may require prior authorization.

7.8 OTHER SERVICES

All services must be medically necessary in order to be covered.

7.8.1 Disease Management for Pain

Structured disease management programs for pain are covered. The program must be directed and overseen by a qualified provider. Prior authorization is required.

7.8.2 Durable Medical Equipment (DME), Supplies & Appliances

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

Some examples of DME, supplies and appliances are:

a. CPAP for sleep apnea
b. Diabetes supplies (see section 7.5.10)
c. Glasses or contact lenses only for the diagnoses of aphakia or keratoconus
d. Hospital beds and accessories
e. Intraocular lenses within 90 days following cataract surgery
f. Light boxes or light wands only when treatment is not available at a provider's office
g. Orthotics, orthopedic braces, orthopedic shoes to restore or maintain the ability to complete activities of daily living or essential job-related activities. If needed correction or support is accomplished by modifying a mass-produced shoe, then the covered expense is limited to the cost of the modification.
h. Oxygen and oxygen supplies
i. Prosthetics
j. Wheelchair or scooter (including maintenance expenses) limited to one per year under age 19 and one every 3 years age 19 and over

The Plan covers the rental charge for DME. For most DME, the rental charge is covered up to the purchase price. Members can work with their providers to order their prescribed DME. Contact Customer Service for help finding a DME provider.

Moda Health encourages the use of a preferred DME provider. Using a preferred DME provider may help members save money. Find a preferred provider using Find Care in the Member Dashboard (see section 5.3.2). A member can change a recurring prescription or automated billing to a preferred DME provider by contacting their current provider and the preferred DME provider to request the change.

All supplies, appliances and DME must be medically necessary. Some require prior authorization (see section 6.1.1). 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 manner to void applicable warranties. Upon request, members must authorize any supplier furnishing DME to provide information related to the equipment order and any other records Moda Health requires to approve a claim payment.

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

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

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

7.8.3 Hearing Services
Hearing tests, hearing aid checks and aided testing are covered twice per year for members under age 4 and once per year for members age 4 and older.

The following items are covered once every 3 years for members under age 26 and once every 4 years for members age 26 and over:

a. One hearing aid per hearing impaired ear
b. Repairs, servicing or alteration of the hearing aid equipment
c. A warranty

Bone conduction sound processors, if necessary for appropriate amplification and prior authorized (the surgery to install the implant is covered at the surgical benefit level) are covered once every 3 years for members under age 26

Hearing assistive technology system, if necessary for appropriate amplification and prior authorized, is covered once every 3 years for members under age 19.

In addition:

a. Ear molds and replacement ear molds 4 times per year under age 8, once per year age 8 to 25, and once every 4 years age 26 and over
b. Initial batteries and one box of replacement batteries per year for each hearing aid for members under age 26
c. Initial batteries once every 4 years for members age 26 and over

Members age 26 and over have a 4 year hearing aid maximum (section 3).

The hearing aid must be prescribed, fitted and dispensed by a licensed audiologist or hearing aid specialist with the approval of a licensed physician. A hearing aid may be covered more frequently if modifications to an existing hearing aid cannot meet the needs of a member under age 19.

To get the highest benefit level for the above hearing services, members can call Hearing Services Customer Service to choose an in-network audiologist and arrange for a hearing exam. The audiologist will help members with their choices of hearing aids available to Plan members by the hearing services vendor through an in-network hearing instrument provider. Members can also use other in-network and out-of-network providers.

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

7.8.4 Home Healthcare

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

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

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

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

This benefit does not include home healthcare, home care services or supplies provided as part of a hospice treatment plan. These are covered under sections 7.8.2 and 7.8.5.

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

7.8.5 Hospice Care

Definitions

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

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

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

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

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

Hospice Inpatient Care

The Plan covers short term hospice inpatient services and supplies.

Respite Care

The Plan covers respite care (as defined in Section 16) provided to a member who requires continuous assistance when arranged by the attending professional provider and prior authorized. Hospice care is covered for services provided in the most appropriate setting. The services and charges of a non-professional provider may be covered for respite care if Moda Health approves in advance.

Exclusions

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

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

7.8.6 Naturopathic Services

Prescribed office supplies and substances approved by the Board of Naturopathic Examiners and dispensed by a professional provider are covered. Vitamins and minerals are covered when medically necessary for treatment of a medical condition and prescribed and dispensed by a

professional provider. This applies whether the vitamin or mineral is oral, injectable or transdermal.

7.8.7 Nonprescription Enteral Formula for Home Use

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

7.8.8 Virtual Care Visits (Telemedicine)

Covered services, when generally accepted healthcare practices and standards determine they can be safely and effectively provided using audio, video or both, are covered when provided by a provider using such telephone or internet conferencing. The application and technology used must meet all state and federal standards for privacy and security of protected health information. Virtual care visits through CirrusMD at cirrusmd.com/modahealth are covered at no cost sharing.

7.9 REFERENCE PRICE PROGRAM

In the reference price program, a set price applies to bariatric surgery, knee/hip replacement and oral appliances (Section 3). Moda Health's networks include providers whose charges are at or below the reference price. If a member receives services from a provider who does not meet the reference price, the member is responsible for the difference between the provider's charge and the reference price. Any amount above the reference price does not apply towards the plan year maximum out-of-pocket or the maximum cost share (sections 4.2 and 4.3). If a member is unable to locate a provider who meets the reference price, or has concerns about the quality of services received from providers who meet the reference price, they should contact Customer Service for assistance.

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

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

a. Are 18 years or older
b. Complete all the requirements listed under section 7.9.1.1 below prior to the surgery and no earlier than 6 months after the date coverage began
c. Meet the requirements as listed under section 7.9.1.2

7.9.1.1 Pre-Surgery Eligibility Requirements:

a. Medical and psychological evaluation
b. A modest weight loss of 5% over 6 months
c. Dietary counseling and evaluation
d. Documented participation in one of the following programs

    i. Minimum of 6 months participation in OEBB Weight Watchers Program or a recognized commercial behavioral weight management program. The treatment program must include hypocaloric diet changes, nutrition education, and physical activity and behavior change strategies

ii. Minimum 6 months participation in a physician, nurse practitioner, physician assistant, registered dietician or licensed behavioral therapist-supervised weight loss program, with or without obesity pharmacotherapy
iii. Three or more primary care visits over a minimum of 6 months with a weight management treatment plan in the medical record
iv. Participation and completion of an 12-week health education weight management program

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

7.9.1.2 Surgery Requirements

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

   i. Sleep apnea uncontrolled on Continuous Positive Airway Pressure (CPAP) or inability to use CPAP with an Apnea/Hypopnea Index (AHI) >15 on sleep study or inability to use CPAP with an AHI >5 and documentation of excessive daytime sleepiness, impaired cognition (ability to think clearly), mood disorders or insomnia, hypertension, ischemic heart disease, or history of stroke
   ii. Congestive heart failure (CHF) or cardiomyopathy with a recommendation for bariatric surgery from a participating physician who is a cardiologist
   iii. Obesity hypoventilation with PC02 ≥45 and a recommendation for bariatric surgery from a participating physician who is a pulmonologist
   iv. Diabetes mellitus uncontrolled (HbA1c8 persistently above 7.5) with conventional medical therapy that includes insulin together with an insulin sensitizing oral agent *i.e.* metformin or pioglitazone (or documented intolerance to insulin or insulin sensitizing oral agents) or > 15 pound weight gain within 2 years of starting insulin therapy
   v. Severe hypertriglyceridemia (>1000 mg/dl) uncontrolled with conventional medical therapy that includes trial of at least two fibrate medications and therapeutic doses of omega-3 fatty acid (6 grams daily), as well as alcohol avoidance
   vi. Hypertension (high blood pressure) with blood pressure >140/90 (130/80 in the presence of diabetes or renal (kidney) disease) documented on two consecutive visits despite use of three antihypertensive medications including a diuretic (increases urination), unless contraindicated
   vii. Refractory extremity edema with ulceration documented by a participating physician
   viii. End-stage renal disease with difficulty dialyzing documented by a participating physician who is a nephrologist (kidney specialist)
   ix. Pseudotumor cerebri documented by a participating physician who is a neurologist
b. BMI ≥40/ m2 with one or more of the above co-morbid conditions and/or have symptomatic degenerative (deteriorating) joint disease of hip, knee or ankle with abnormal x-rays
c. BMI ≥50/m2 (no co-morbid condition required)
d. BMI ≥ 60:
   i. For members with a BMI ≥60 and/or members 60 years of age or higher, surgical risk decisions regarding the appropriateness of surgery will be made individually based on rehabilitation potential and the participating provider's judgment regarding surgical risk and likelihood of benefit

ii. For members with a BMI between 60 and 70, decisions regarding surgical timing will be made individually based on rehabilitation potential and the participating provider's judgment regarding surgical risk and benefit
iii. Surgery is not felt to be appropriate for extreme levels of obesity (BMI >70) and non-surgical strategies for weight loss will be recommended

7.9.1.3 Bariatric Surgery Services Limitations:

a. Services in 7.9.1 are for members age 18 and over only
b. Only Roux-en-Y gastric bypass or gastric sleeve surgery will be performed
c. Surgeries will only be performed at a defined network of Centers of Excellence
d. A facility reference price of $20,000 or 200% of the amount paid by Medicare for facilities subject to ORS 243.879. Complications are not subject to reference pricing
e. Members not eligible for bariatric surgery are not eligible for coverage of complications

7.9.1.4 Definitions:

a. **Centers of Excellence** (COE) means a healthcare facility and/or team of professional providers with which Moda Health has contracted and arranged to provide facility services for Roux-en-Y gastric bypass or gastric sleeve surgery. Centers of Excellence have rigorous standards based on best practices and have exceptional skills and expertise in managing patients with a specific condition.

7.9.1.5 Travel Benefit:

The Plan will reimburse up to $2,600 for qualified travel expenses to a COE. Per diem and milage limitations are based on the federal government allowances from the US General services Administration (GSA). To qualify for reimbursement, a member must:
a. Live more than 120 miles from a Center of Excellence, and
b. Submit receipts for all travel expenses as proof of payment.

Benefit includes:

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

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

7.9.2 Knee/Hip Replacement

A covered knee or hip replacement, including partial replacement and resurfacing, is subject to reference pricing (Section 3). For more information regarding the Reference Price Program for knee/hip replacement, go to www.modahealth.com/oebb/members/act/procedures.shtml

7.9.2.1 Limitations:

a. A facility reference price of $25,000 or 200% of the amount paid by Medicare for facilities subject to ORS 243.879
b. If a member chooses not to use a reference price based facility, the member will be responsible for charges in excess of the reference price

c. Complications of a covered surgery are not subject to reference pricing

7.9.2.2 Travel Benefit:

The Plan will reimburse up to $2,600 for qualified travel and lodging expenses for the member and one guest. To qualify for lodging reimbursement, the member must live more than 120 miles from the surgery facility. Per diem and mileage limitations are based on the federal government allowances from the US General services Administration (GSA). Receipts for travel expenses must be submitted as proof of payment.

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

*Additional post surgery follow-up trips may be covered if medically necessary.

7.9.3 Oral appliance

Expenses for an oral appliance are covered up to a per appliance reference price (Section 3). Members with any questions regarding coverage should contact Customer Service.

7.10 PHARMACY PRESCRIPTION BENEFIT

Prescription medications provided when a member is admitted to the hospital are covered by the medical plan as an inpatient expense; the prescription medications benefit described here does not apply.

7.10.1 Definitions

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

Brand Substitution. Is a policy on how prescription medications are filled at the pharmacy. Both generic and brand medications are covered. If a member requests, or the treating professional provider prescribes, a brand medication when a generic equivalent is available, the member may be responsible for the nonpreferred cost sharing plus the difference in cost between the generic and brand medication. As the difference in cost between the generic and the brand medication is not a covered expense, the member will at all times be responsible for payment of this difference. The difference in cost between the generic and brand medication does not apply towards the member's plan year maximum cost share.

Formulary is a listing of all prescription medications and their coverage under the pharmacy prescription benefit. A prescription price check tool is available on Member Dashboard under the pharmacy tab. This online formulary tool provides 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 alternative and are often the most cost effective option. Generic medications must contain the same active ingredients as their brand counterpart and be identical in strength, dosage form and route of administration.

Nonpreferred Tier Medications. Non-preferred tier medications are excluded unless a formulary exception is requested and approved. These medications are not designated as preferred, have been reviewed by Moda Health and do not have significant therapeutic advantage over their

preferred alternative(s). These products are usually not recommended as first line therapy and different methods of treatment exist. See section 7.10.4 for information about making a formulary exception request.

Over the Counter (OTC) Medications are medications that may be purchased without a professional provider's prescription. Moda Health follows the federal designation of OTC medications to decide if an OTC medication is covered by the Plan.

Prescription Medication List means the Moda Health Prescription Medication List. The list is available on the Member Dashboard. It provides information about the coverage of commonly prescribed medications. It is not an all-inclusive list of covered products. Medications that are new to the market are subject to review and may have additional coverage limitations established by Moda Health.

The prescription medication list and the tiering of medications may change and will be periodically updated. A prescription price check tool is available on the Member Dashboard under the pharmacy tab. Members with any questions regarding coverage should contact Customer Service.

Moda Health is not responsible for any prescribing or dispensing decisions. These decisions are to be made by the professional provider and pharmacist using their professional judgment. Members should talk with their professional providers about whether a medication from the list is appropriate for them. This list is not meant to replace a professional provider's judgment when making prescribing decisions.

Preferred Tier Medications means those medications, including specialty preferred medications, that have been reviewed by Moda Health and found to be safe and clinically effective at a favorable cost when compared to other medications in the same therapeutic class and/or category. Generic medications may be included in this tier when they 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 7.10.4 for information about making a formulary exception request.

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

Select Tier Medications include those generic medications that are safe and effective, and represent the most cost effective option within their therapeutic category.Certain brand medications that are both clinically favorable and cost effective are also included.

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

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

Value Tier Medications are medications that include commonly prescribed products used to treat chronic medical conditions, and that are considered safe, effective and cost-effective to alternative medications. A list of value tier medications is available on the Member Dashboard.

7.10.2 Covered Expenses

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

a. It is for a covered medication supply that is prescribed for a member, or
b. Is for an OTC contraceptive the member has bought
c. It is incurred while the member is eligible under the Plan
d. The prescribed medication is not excluded

A covered expense must be medically necessary, defined as delivery of a service by a qualified healthcare provider, exercising prudent clinical judgement, that meets all of the following:

a. Is for the purpose of preventing, evaluating, diagnosing or treating a medical condition or its symptoms
b. Meets generally accepted standards of medical practice
c. Is proven to produce intended effects on health outcomes (e.g., morbidity, mortality, quality of life, symptom control, function) associated with the member's medical condition or its symptoms
d. Has beneficial effects on health outcomes that outweigh the potential harmful effects
e. Is clinically appropriate in terms of type, frequency, extent, site and duration
f. Is not primarily for the convenience of the patient or healthcare provider
g. Is at least as likely to produce equivalent therapeutic or diagnostic results for the diagnosis or treatment of the member's medical condition or its symptoms as an alternative service or therapy, including no intervention, and is not more costly than an alternative service or sequence of services.

For these purposes, "generally accepted standards of medical practice" are standards based on reliable scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations, and the views of physicians practicing in relevant clinical areas, and other relevant factors. For new treatments, effectiveness is determined by reliable scientific evidence that is published in peer-reviewed medical literature. For existing treatments, effectiveness is determined first by scientific evidence, then by professional standards, then by expert opinion. The fact that medications are FDA approved and were furnished, prescribed or approved by a physician or other qualified provider does not in itself mean that they are medically necessary.

7.10.3 Covered Medication Supply

Includes the following:

a. A prescription medication that is medically necessary for treatment of a medical condition
b. Compounded medications containing at least one covered medication as the main ingredient
c. Insulin and diabetic supplies including insulin syringes, needles and lancets, glucometers and test strips. Must have a valid prescription and use a preferred manufacturer
d. Certain prescribed preventive medications required under the Affordable Care Act
e. Medications for treating tobacco dependence, including OTC nicotine patches, gum or lozenges, with a valid prescription and from an in-network retail pharmacy are covered with no cost sharing as required under the Affordable Care Act

f. Prescription contraceptive medications and devices for birth control (section 7.4.3) and medical conditions covered under the Plan. Each contraceptive can be filled by the pharmacy up to a 3-month supply for the member's first use of the medication and up to a 12-month supply for subsequent fills. Contact Customer Service for information on how to obtain a 12-month supply.
g. Certain immunizations and related administration fees are covered with no cost sharing at in-network retail pharmacies (e.g. flu, pneumonia and shingles vaccines)

Certain prescription medications and/or quantities of prescription medications may require prior authorization (see Section 6). Some medications used to treat complex chronic health conditions must be dispensed through a Moda-designated specialty pharmacy provider.

For assistance coordinating prescription refills, contact Pharmacy Customer Service. Emergency insulin refills and supplies are limited to the lesser of the smallest available package or a 30-day supply and are covered no more than 3 times per year.

7.10.4 Formulary Exception Requests

Requests for formulary exceptions can be made by the member or professional provider through Member Dashboard or by contacting Customer Service. Formulary exceptions must be based on medical necessity. The prescribing professional provider's contact information must be submitted, as well as information to support the medical necessity, including all of the following:

a. Formulary medications were tried with an adequate dose and duration of therapy
b. Formulary medications were not tolerated or were not effective
c. Formulary or preferred medications would reasonably be expected to cause harm or not produce equivalent results as the requested medication
d. The requested medication therapy is evidence-based and generally accepted medical practice

Moda Health will contact the prescribing professional provider to find out how the medication is being used in the member's treatment plan. Standard exception requests are determined within 72 hours. Urgent requests are determined within 24 hours.

7.10.5 90-Day Supply at Participating Retail Pharmacies

Members may buy a 90-day supply from participating retail pharmacies at the preferred discount. Not all medications are eligible for a 90-day supply. All standard benefit and administrative provisions apply. Search for participating pharmacies through the Member Dashboard. Participating pharmacies will say "3 months" under the Days Supply column in their details.

7.10.6 Mail Order Pharmacy

Members can choose to fill prescriptions for covered medications through a Moda-designated mail order pharmacy. Prescriptions purchased through the mail order drug program are subject to the Moda Health brand substitution policy. A mail order pharmacy form can be obtained from the Member Dashboard or by contacting Customer Service.

7.10.7 Specialty Services & Pharmacy

Specialty medications are often used to treat complex chronic health conditions. The pharmacist and other professional providers will tell a member if a prescription requires prior authorization or must be obtained from a Moda-designated specialty pharmacy. Information about the clinical services and a list of covered specialty medications is available on the Member Dashboard or by contacting Customer Service.

Most specialty medications must be prior authorized. If a member does not purchase specialty medications at the Moda-designated specialty pharmacy, the expense will not be covered. Some specialty prescriptions may have shorter day supply coverage limits. Some medications may be eligible for a 90-day supply. For some specialty medications, members may be required to enroll in programs to ensure proper medication use and/or reduce the cost of the medication. More information is available on the Member Dashboard or by contacting Customer Service.

7.10.8 Self-Administered Medication

All self-administered medications are subject to the prescription medication requirements of section 7.10. Self-administered specialty medications are subject to the same requirements as other specialty medications (section 7.10.7).

Self-administered injectable medications are not covered when supplied in a provider's office, clinic or facility.

7.10.9 Step Therapy

When a medication is part of the step therapy program, members 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 the member has 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, the provider will need to prescribe the Step 1 medication.

7.10.10 Limitations

The following limitations apply:

a. New FDA approved medications are subject to review and may have additional coverage requirements or limits set by the Plan. A member or prescriber can request a medical necessity evaluation if a newly approved medication is initially denied during the review period.
b. If a brand medication is filled by the pharmacy when a generic equivalent is available, the member may have to pay the difference in cost between the generic and brand medication. Expenses incurred due to brand substitution do not count toward the out-of-pocket maximum.
c. Starting treatment with a medication, whether by the use of free samples or otherwise, does not bypass the Plan's requirements (e.g., step therapy, prior authorization) before Plan benefits are payable.
d. Some specialty medications that have been found to have a high discontinuation rate or short durations of use may be limited to a 15-day supply.
e. Medications with dosing intervals greater than the Plan's maximum day supply will have an increased copayment to match the day supply.
f. Medications purchased outside of the United States and its territories are only covered in emergency and urgent care situations.

g. Early refill of medications for travel outside of the United States will be reviewed. When allowed, early refill is limited to once every 6 months. Early refill cannot be used to cover a medication supply beyond the end of the plan year.

7.10.11 Exclusions

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

a. **Devices.** Including, but not limited to therapeutic devices and appliances. Information for contraceptive devices is in section 7.10.3 and for other devices in section 7.8.2
b. **Foreign Medication Claims.** Medications purchased from non-U.S. mail order or online pharmacies or U.S. mail or online pharmacies acting as agents of non-U.S. pharmacies
c. **Hair Growth Medications.**
d. **Immunization Agents for Travel.** Except as required under the Affordable Care Act
e. **Institutional Medications.** To be taken by or administered to a member while they are a patient in a hospital, rest home, skilled nursing facility, extended care facility, nursing home or similar institution
f. **Medication Administration.** A charge for administration or injection of a medication, except for certain 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 Prescribed by a Relative.** Prescriptions written or ordered by members or their relatives, including a spouse, domestic partner, child, sibling, or parent of a member or their spouse or domestic partner
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 approved by Oregon's Health Evidence Review Commission or Pharmacy Therapeutics and Review Committee
l. **Over the Counter (OTC) Medications** and certain prescription medications for which there is an OTC equivalent or alternative, except for contraceptives or those treating tobacco dependence
m. **Repackaged Medications.**
n. **Replacement Medications and/or Supplies.**
o. **Sexual Disorders.** Except gender identity medications or devices prescribed or used to treat sexual dysfunction
p. **Untimely Dispensing.** Drugs or medicines that are dispensed more than one year after the order of a professional provider
q. **Vitamins and Minerals.** Over-the-counter (OTC) vitamins and minerals, except those required by the U.S. Preventive Services Task Force
r. **Weight Loss Medications.**

SECTION 8. GENERAL EXCLUSIONS

In addition to the limitations and exclusions described elsewhere in the Plan, the following services, supplies (including medications), procedures and conditions are not covered, even if otherwise medically necessary, if they relate to a condition that is otherwise covered by the Plan, or if recommended, referred, or provided by a professional provider. Any direct complication or consequence that arises from these exclusions will not be covered except for emergency medical conditions. The Plan does not exclude services solely because an injury results from an act of domestic violence.

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

Charges Over the Maximum Plan Allowance
Except when required under the Plan's coordination of benefits rules (see section 11.4.1)

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

Cosmetic Procedures
Any procedure or medication requested for the purpose of improving or changing appearance without restoring impaired body function, including rhinoplasty, breast augmentation, lipectomy, liposuction, and hair removal (including electrolysis and laser). Exceptions are provided for reconstructive surgery if medically necessary and not specifically excluded (see sections 7.6.11, 7.6.12 and 7.5.12).

Court Ordered Sex Offender Treatment

Custodial Care
Routine care and hospitalization that helps a member with activities of daily living, such as bathing, dressing, getting in and out of bed, preparation of special diets and supervision of 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 as specifically provided for in sections 7.5.9 and 7.5.16, or if medically necessary to restore function due to craniofacial anomaly

Educational Supplies
Including books, tapes, pamphlets, subscriptions, videos and computer programs (software). Educational programs as required under the ACA or mental health parity are not part of this exclusion.

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

Experimental or Investigational Procedures
Including expenses incidental to or incurred as a direct consequence of such procedures (see definition of experimental/investigational in Section 16)

Faith Healing

Financial Counseling Services

Food Services
Meals on Wheels and similar programs

Guest Meals in a Hospital or Skilled Nursing Facility

Hearing Aids
Except as specifically provided for in section 7.8.3

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

Homemaker or Housekeeping Services

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

Infertility
Donor compensation for time and efforts, services for unenrolled surrogate mothers and advanced reproductive services for infertility are not covered. Advanced reproductive services include In-vitro Fertilization (IVF), Zygote Intra-Fallopian Transfer (ZIFT), Gamete Intra-Fallopian Transfer (GIFT), Pre-Implantation Genetic Diagnosis (PGD), Intractoplasmic Sperm Injection (ICSI), ovum microsurgery, reversal of voluntary sterilization, and freezing or storage of eggs or sperms when the member does not have a cancer diagnosis. See section 7.7.8 for covered infertility services. Includes surgery to reverse elective sterilization (vasectomy or tubal ligation).

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

Legal Counseling

Massage or Massage Therapy

Mental Examination and Psychological Testing and Evaluations
For the purpose of adjudication of legal rights, administrative awards or benefits, corrections or social service placement, employment, or any use except as a diagnostic tool for the treatment of a mental health condition or as specifically provided for in section 7.5.6

Missed Appointments

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

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

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

Nutritional Counseling
Except as provided for in section 7.5.19

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

a. Gastric restrictive procedures with or without gastric bypass (except as provided in section 7.9.1), or the revision of such procedures
b. Weight management services such as weight loss programs, exercise programs, counseling, hypnosis, biofeedback, neurolinguistic programming, guided imagery, relaxation training and subliminal suggestion used to modify eating behaviors
c. Any medication or formula related to or resulting from the treatment of weight loss or obesity even if prescribed by a physician

The Plan covers services and supplies that are necessary for the treatment of established medical conditions that may be caused by or made worse by obesity, but services and supplies that do so by treating the obesity directly are not covered, except as required under the Affordable Care Act and as provided in section 7.9.1.

Orthopedic Shoes
Except as provided for in section 7.8.2

Orthognathic Surgery
Including associated services and supplies

Pastoral and Spiritual Counseling

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

Physical Exercise Programs

Private Nursing Services

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

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

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

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

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

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

Self-Administered Medications
Including oral and self-injectable when provided directly by a physician's office, facility or clinic instead of through the pharmacy prescription medication or anticancer benefits (sections 7.10.8 and 7.5.2).

Self Help Programs

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

Services Otherwise Available
Including those services or supplies:

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

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

Services Provided by Volunteer Workers

Sexual Dysfunction of Organic Origin
Services for sexual dysfunctions of organic origin, including impotence and decreased libido. This exclusion does not extend to sexual dysfunction diagnoses listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders.

Support Education
Including:

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

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

Taxes

Telehealth
Including telephone visits or consultations and telephone psychotherapy, except telemedicine as specifically provided for in section 7.8.8. This exclusion does not apply to covered case management services.

Telephones and Televisions in a Hospital or Skilled Nursing Facility

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

Third Party Liability Claims
Services and supplies for treatment of a medical condition for which a third party is or may be responsible, to the extent of any recovery received from or on behalf of the third party (see section 11.4.2)

Transportation
Except medically necessary ambulance transport

Treatment in the Absence of Illness
Including individual or family counseling or treatment for marital, behavioral, financial, family, occupational or religious problems, treatment for at risk individuals in the absence of illness or a diagnosed mental health or chemical dependence condition, or treatment of normal transitional response to stress

Treatment After Coverage Ends
The only exception is if a member is hospitalized at the time the Plan ends and services continue to meet the criteria for medical necessity (see section 7.1), or for covered hearing aids ordered before coverage ends and received within 90 days of the end date.

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

Treatment Not Medically Necessary
Including services or supplies that are:

a. Not medically necessary for the treatment or diagnosis of a condition otherwise covered under the Plan or are prescribed for purposes other than treating disease
b. Inappropriate or inconsistent with the symptoms or diagnosis of a member's condition
c. Not established as the standard treatment by the medical community in the service area in which they are received
d. Primarily rendered for the convenience of a member or a provider
e. Not the least costly of the alternative supplies or levels of service that can be safely provided to a member.

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 as otherwise provided under the Plan. See section 7.5.10 for coverage of annual dilated eye exam for management of diabetes.

Vision Surgery
Any procedure to cure or reduce myopia, hyperopia, or astigmatism. Includes reversals or revisions of any such procedures and 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 arising out of or in the course of employment or self-employment for wages or profit, unless the expense is denied as not work related under any workers' compensation provision. A claim must be filed for workers' compensation benefits and a copy of the workers' compensation denial letter must be submitted for payment to be considered. This exclusion does not apply to owners, partners or executive officers if they are exempt from workers' compensation laws and the Group does not provide workers' compensation coverage to them.

SECTION 9. ELIGIBILITY

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

9.1 ELIGIBILITY AUDIT

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

SECTION 10. ENROLLMENT

10.1 NEWLY-HIRED AND NEWLY-ELIGIBLE ACTIVE ELIGIBLE EMPLOYEES

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

10.2 QUALIFIED STATUS CHANGES

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

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

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

The special enrollment rights as described above apply:

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

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

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

10.3 EFFECTIVE DATES

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

10.4 OPEN ENROLLMENT

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

10.5 LATE ENROLLMENT

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

10.6 RETURNING TO ACTIVE ELIGIBLE EMPLOYEE STATUS

The Plan's enrollment rules for those persons returning to active eligible employee status are outlined in the Oregon Administrative Rules under OAR 111-040-0011.

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

10.7 REMOVING AN INELIGIBLE INDIVIDUAL FROM BENEFIT PLANS

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

A subscriber is responsible for notifying the Group if a dependent becomes ineligible for the Plan within 31 days of the qualified status change. A subscriber's failure to report a qualified status change within 31 days is considered an intentional misrepresentation of fact which is material to enrollment in the Plan and may be grounds to terminate the benefits of an ineligible dependent effective the first of the month following the loss of eligibility.

10.8 WHEN COVERAGE ENDS

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

10.8.1 Termination of the Group Plan

Coverage ends for OEBB and members on the date the Plan ends. There is one exception to this rule. If OEBB terminates the Plan and immediately replaces it with a policy through another carrier, coverage under the Plan shall continue for members who are hospitalized on the day the Plan ends until the hospital confinement ends.

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

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

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

10.8.2 Termination by Subscriber

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

10.8.3 Rescission By The Plan

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

10.8.4 Other

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

10.9 DECLINATION OF COVERAGE

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

SECTION 11. CLAIMS ADMINISTRATION & PAYMENT

11.1 SUBMISSION & PAYMENT OF CLAIMS

A claim is not payable until the service or supply has actually been received. In no event, except absence of legal capacity or in the case of a Medicaid claim, is a claim valid if submitted later than 12 months from the date the expense was incurred. Claims submitted by Medicaid must be sent to Moda Health within 3 years after the date the expense was incurred.

Moda Health does not always pay claims in the order in which charges are incurred. This may affect how a member's cost sharing is applied to claims. For example, a deductible may not be applied to the first date a member is seen in a benefit year if a later date of service is paid first.

11.1.1 Hospital & Professional Provider Claims

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

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

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

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

and include all of the following information:

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

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

For care received outside the United States, see section 11.1.4.

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

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

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

11.1.4 Out-of-Country or Foreign Claims
When care is received outside the United States, the member must provide all of the following information to Moda Health:

a. Patient's name, subscriber's name, and group and identification numbers
b. Statement explaining where the member was and why they sought care
c. Copy of the medical record (translated is preferred if available)
d. Itemized bill for each date of service
e. Proof of payment in the form of a credit card/bank statement or cancelled check

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

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

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

11.2 COMPLAINTS, APPEALS & EXTERNAL REVIEW

Before filing an appeal, it may be possible to resolve a dispute with a phone call to Customer Service.

11.2.1 Definitions
For purposes of section 11.2, the following definitions apply:

Adverse Benefit Determination means a letter or an Explanation of Benefits (EOB) from Moda Health informing that a person is not eligible for benefits or that benefits have not been fully paid. Reasons are:

a. Rescission of coverage (section 10.8.3)
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 11.3) is denied because the course of treatment is not considered active

A **Final Internal Adverse Benefit Determination** is an adverse benefit determination that has been upheld by Moda Health at the end of the internal appeal process, or the internal appeal process has been finished.

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

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

Complaint means an expression of dissatisfaction about a specific problem a member has had or about a decision by Moda Health or an agent acting for Moda Health or a provider. It includes a request to resolve the problem or change the decision. Asking for information or clarification about the Plan is not a complaint.

Expedited (fast) appeal means any appeal requested when using the regular time period to review a denial of a pre-service appeal could

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

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

Pre-service appeal means any appeal for a benefit requested under the Plan for care or services that require prior authorization and the services have not been received.

Utilization Review means a system of reviewing the medical necessity, appropriateness, or quality of medical care services and supplies. An adverse benefit determination that the item or service is not medically necessary or appropriate, is investigational or experimental, or in which the decision as to whether a benefit is covered involved a medical judgment is a utilization review decision.

11.2.2 Time Limit for Submitting Appeals

A member has **180 days** from the date an adverse benefit determination is received to submit the first written appeal. If appeals are not submitted within the timeframes in these sections, the member will lose the right to any appeal.

11.2.3 The Review Process

The Plan has a 2-level internal review process (a first level appeal and a second level appeal). If a member is not satisfied with the result of the second level appeal, they may ask for external review by an independent review organization. The first and second levels of appeal must be finished before a member can ask for external review, unless Moda Health agrees to skip the internal reviews.

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, Moda Health will continue to provide benefits while the appeal is being reviewed. If the decision is upheld, the member will have to pay back the cost of coverage received during the review period.

The timelines in the sections below do not apply when the member does not reasonably cooperate, or circumstances beyond the control of either party (Moda Health or the member) makes it impossible to comply with the requirements. Whoever is unable to comply must give notice of the specific reason to the other party when the issue arises.

A member may review the claim file and submit written comments, documents, records and other information to support the appeal. A member may choose a person (representative) to act on their behalf.

11.2.4 First Level Appeals

An appeal must be submitted in writing. If necessary, Customer Service can help with filing an appeal. Moda Health will send a letter no more than 7 days after receiving an appeal to tell the member that the appeal is received. Appeals are investigated by persons who were not involved in the original decision.

Expedited appeals can have a faster review upon request. Fast reviews will be finished within 72 hours in total for the first and second level appeals combined after Moda Health has received those appeals. The time between the first level appeal decision and when Moda Health receives the second level appeal does not count. If the member does not provide enough information for Moda Health to make a decision at each appeal level, Moda Health will tell the member and/or provider within 24 hours of receipt of the appeal of the specific information needed to make a decision. The member or provider must provide the specified information as soon as possible. Moda health will make a decision on a fast appeal no later than 48 hours after the earlier of (a) Moda Health's receipt of the specified information, or (b) the end of the time allowed to submit the specified additional information.

When an investigation is finished, Moda Health will send a written notice of the decision to the member, including the reason for the decision. This notice will be sent within 15 days of a pre-service appeal or 30 days of a post-service appeal.

11.2.5 Second Level Appeals

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

Investigations and responses to a second level appeal will be by persons who were not involved in the initial decisions, and will follow the same timelines as those for a first level appeal. If new or additional evidence or reasoning is used by Moda Health in connection with the appeal, it will be provided to the member, in advance and free of charge, before any final internal adverse

benefit determination. Members may respond to this information before Moda Health's decision is finalized. Moda Health will send a written notice of the decision to the member, including the reason for the decision.

11.2.6 External Review

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

a. The member must sign an authorization to disclose protected health information allowing the IRO to see their medical records. This form will be included in Moda Health's response to the appeal, or contact Customer Service for a copy. It should be returned with the external review request, If the release is not returned within 5 days of Moda Health's receipt of the request, the external review will be delayed.
b. The request for external review (including the Protected Health Information form) must be in writing to the Appeals Department (see section 2.1) no more than 180 days after receipt of the final internal adverse benefit determination. If necessary, Customer Service can help with filing the request. A member may submit additional information to the IRO within 5 days, or 24 hours for a fast review
c. Generally, the member must have exhausted the appeal process described in sections 11.2.4 and 11.2.5. However, Moda Health may agree to skip this requirement and send an appeal directly to external review if the member agrees. For a fast appeal or when the appeal is about a condition for which a member received emergency services and is still hospitalized, a request for external review may be expedited or at the same time as a request for internal appeal review

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

a. An adverse determination based on a utilization review decision
b. Whether a course or plan of treatment that a member is undergoing is an active course of treatment for purposes of continuity of care (see section 11.3)
c. Cases in which Moda Health does not meet the internal timeline for review or the federal requirements for providing related information and notices

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

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

11.2.7 Complaints

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

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

Review of a complaint will be completed within 30 days. If more time is needed, Moda Health will tell the member and have 15 more days to make a decision.

11.2.8 Additional Member Rights

Members have the right to file a complaint or ask for help from the Oregon Division of Financial Regulation.

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

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

11.3 CONTINUITY OF CARE

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

Moda Health will tell members who are under the care of a particular professional provider when this happens, and let them know about their right to continuity of care.

Eligible members

a. Will get a letter from Moda Health
    i. No more than 10 days after the date the contract ends, or
    ii. no more than 10 days after Moda Health first learns that a member had been seeing that provider for ongoing care
    iii. When the professional provider is part of a group of providers, the provider group may give this notice
    iv. When a member requests continuity of care before Moda Health sends its notice, the member is considered notified as of that date
b. Are under the care of a professional provider whose contract with Moda Health ends
    i. The care is an active course of treatment that is medically necessary
    ii. Pregnancy care is in at least the second trimester
    iii. The professional provider and the member agree that it is a good idea to maintain continuity of care
c. Requests continuity of care from Moda Health

The professional provider must agree to follow the requirements of the medical services contract that had most recently been in effect between the professional provider and Moda Health, and to accept the contractual reimbursement applicable at the time the contract ended.

Continuity of care ends

a. On the earlier of the following dates for most members:
    i. The day after the member finishes the active course of treatment that gives them the right to continuity of care

ii. 120 days after the date Moda Health tells the member the contract with the professional provider has ended

b. On the later of the following dates for pregnancy care that is in at least the 2nd trimester:
   i. 45 days after the birth
   ii. As long as the member continues under an active course of treatment, but not later than 120 days after the date Moda Health tells the member the contract with the professional provider has ended

When continuity of care is not available:

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

11.4 BENEFITS AVAILABLE FROM OTHER SOURCES

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

11.4.1 Coordination of Benefits (COB)

Coordination of benefits applies when a member has healthcare coverage under more than one plan. If the member is covered by another plan or plans, the benefits under this Plan and the other plan(s) will be coordinated. This means one plan pays its full benefits first, and then any other plans pay. The order of benefit determination rules govern the order in which each plan will pay a claim for benefits. (For coordination with Medicare, see section 11.5)

11.4.1.1 Order of Benefit Determination (Which Plan Pays First?)

The first of the following rules that applies will govern:

a. **Non-dependent/Dependent.** If a plan covers the member as other than a dependent (e.g., an employee, member of an organization, primary insured, or retiree), then that plan will determine its benefits before a plan that covers the member as a dependent. However, if the member is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the member as a dependent and primary to the plan covering the member as other than a dependent (e.g. a retired employee), then the order of benefits between the 2 plans is reversed.
b. **Dependent Child/Parents Married or Living Together.** If the member is a dependent child whose parents are married or are living together whether or not they have ever been married or domestic partners, the plan of the parent whose birthday falls earlier in the calendar year is the primary plan. If both parents' birthdays are on the same day, the plan that has covered the parent the longest is the primary plan. (This is called the birthday rule.)
c. **Dependent Child/Parents Separated or Divorced or Not Living Together.** If the member is a dependent child of divorced or separated parents, or parents not living together whether or not they have ever been married or domestic partners, then the following rules apply:

i. If a court decree states that one of the parents is responsible for the healthcare expenses of the child, and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to plan years beginning after the plan is given notice of the court decree.
ii. If a court decree states that both parents are responsible for the healthcare expenses of the child, or that the parents have joint custody without specifying that one parent is responsible, the birthday rule described above applies.
iii. If there is not a court decree allocating responsibility for the child's healthcare expenses, the order of benefits is as follows: The plan covering the
    A. Custodial parent
    B. Spouse or domestic partner of the custodial parent
    C. Non-custodial parent
    D. Spouse or domestic partner of the non-custodial parent

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

11.4.1.2 How COB Works

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

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

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

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

11.4.1.3 Effect on the Benefits of this Plan

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

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

11.4.1.4 Pharmacy COB

Claims subject to the COB provision of the Plan may be submitted electronically by pharmacies or through the direct member reimbursement paper claim process. The preferred method is for the pharmacy to electronically transmit the primary plan's remaining balance to Moda Health for processing. If approved, the secondary claim will be automatically processed according to plan benefits. Members who are unable to have their secondary claims processed electronically may submit a claim reimbursement request directly to Moda Health (see section 11.1.3).

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

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

Approved by Primary:

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

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

11.4.1.5 Definitions

For purposes of section 11.4.1, the following definitions apply:

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

Plan includes:

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

Plan does not include:

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

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

Complying plan is a plan that follows these COB rules.

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

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

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

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

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

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

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

Custodial parent is the parent awarded custody by a court decree. If there is no court decree, it is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

11.4.2 Third Party Liability

A member may have a legal right to recover benefit or healthcare costs from a third party as a result of a medical condition for which such costs were paid by Moda Health, as administrator of the Plan. The Plan does not cover benefits for which a third party may be legally liable, except for those related to a motor vehicle accident (see section 11.4.3 for motor vehicle accident recovery). Because recovery from a third party may be difficult and take a long time, as a service to the member Moda Health will pay a member's expenses based on the understanding and agreement

that Moda Health is entitled to be reimbursed from any recovery the member may receive for any benefits paid that are or may be recoverable from a third party, as defined below.

The member agrees that Moda Health, on behalf of the Plan, has the rights described in section 11.4.2. Moda Health may seek recovery under one or more of the procedures outlined in this section. The member agrees to do whatever is necessary to fully secure and protect, and to do nothing to prejudice, Moda Health's right of recovery on behalf of the Plan or subrogation as discussed in this section.

11.4.2.1 Definitions

For purposes of section 11.4.2, the following definitions apply:

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

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

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

11.4.2.2 Subrogation

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

11.4.2.3 Right of Recovery

In addition to its subrogation rights, Moda Health, as administrator of the Plan, may, at its sole discretion and option, require a member, and their attorney, if any, to protect its recovery rights. The following rules apply to all recovery except for those related to motor vehicle accidents (see section 11.4.3 for motor vehicle recovery rights):

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

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

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

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

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

11.4.2.4 Additional Provisions

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

a. The member shall cooperate with Moda Health to protect its recovery rights, including by:
    i. Signing and delivering any documents Moda Health reasonably requires to protect its rights, including a Third Party Reimbursement Questionnaire and Agreement. If the member has retained an attorney, then the attorney must also sign the agreement.
    ii. Providing any information to Moda Health relevant to the application of the provisions of section 11.4.2, including all information available to the member, or any representative or attorney representing the member, relating to the potential third party claim. This may include medical information, settlement correspondence, copies of pleadings or demands, and settlement agreements, releases or judgments
    iii. Notifying Moda Health of the potential third party claim for which the Plan may issue benefits. The member has this responsibility even if the first request for payment of benefits is a bill or invoice submitted to Moda Health by the member's provider
    iv. Taking such actions as Moda Health may reasonably request to assist it in enforcing its third party recovery rights

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

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

d. The member agrees that Moda Health may notify any third party, or third party's representatives or insurers, of its recovery rights described in section 11.4.2.

e. Even without the member's written authorization, Moda Health may release to, or obtain from, any other insurer, organization or person, any information it needs to carry out the provisions of section 11.4.2.

f. Section 11.4.2 applies to any member for whom advance payment of benefits is made by the Plan whether or not the event giving rise to the member's injuries occurred before the member became covered by Moda Health.

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

h. If the member or the member's representatives fail to do any of the above mentioned acts, then Moda Health has the right to not advance payment or to suspend payment of any benefits, or to recover any benefits it has advanced, for any medical condition resulting from the event giving rise to, or the allegations in, the third party claim except for claims related to motor vehicle accidents (see section 11.4.3). Moda Health may notify medical providers seeking authorization of payment of benefits that all payments have been suspended and may not be paid.

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

11.4.3 Motor Vehicle Accident Recovery

If a claim for healthcare expenses arising out of a motor vehicle accident is filed with the Plan and motor vehicle insurance has not yet paid, Moda Health, as administrator of the Plan, will advance benefits. Moda Health, on behalf of the Plan, retains the right to repayment of any benefits paid from the proceeds of any settlement, judgement or other payment received by the member that exceeds the amount that fully compensates the member for their motor vehicle accident related injuries.

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

The member shall do whatever is proper to secure, and may not prejudice, the rights of the Plan under this section.

11.4.4 Surrogacy

Members who enter into a surrogacy agreement must reimburse the Plan for covered services related to conception, pregnancy, delivery or postpartum care that are received in connection with the surrogacy agreement. The amount the member must pay will not exceed the payments or other compensation they and any other payee is entitled to receive under the surrogacy agreement. Any cost sharing amounts the member pays will be credited toward the amount owed under this section.

By accepting services, the member assigns Moda Health, as administrator of the Plan, the right to receive payments that are payable to the member or any other payee under the surrogacy agreement, regardless of whether those payments are characterized as being for medical expenses. Moda Health, on behalf of the Plan, will secure its rights by having a lien on those payments and on any escrow account, trust or other account that holds those payments. Those payments shall first be applied to satisfy the Plan's lien.

Within 30 days after entering a surrogacy agreement, the member must send written notice of the agreement, a copy of the agreement, and the names, addresses and telephone numbers of all parties involved in the agreement to Moda Health. The member must also complete and send to Moda Health any consents, releases, authorizations, lien forms and other documents necessary for Moda Health to determine the existence of any rights it may have under this section and to satisfy those rights.

If the member's estate, parent, guardian or other party asserts a claim against a third party based on the surrogacy agreement, such person or entity shall be subject to the Plan's liens and other rights to the same extent as if the member had asserted the claim against the third party.

11.5 MEDICARE

The Plan coordinates benefits with Medicare as required under federal government rules and regulations. This includes coordinating to the Medicare allowable amount. To the extent permitted by law, if the Plan is secondary to Medicare, the Plan will not pay for any part of a covered expense that is actually paid under Medicare or would have been paid under Medicare Part B if the member had enrolled in Medicare when eligible. The Plan will estimate what Medicare would have paid and reduce its benefits based on the estimate. In addition, if the Plan is secondary to Medicare, Moda Health will not pay for any part of expenses incurred from providers who have opted out of Medicare participation.

The Plan may estimate Medicare's payment when:

a. The Plan is a retiree plan
b. The member is on COBRA (does not apply to ESRD, below)
c. The member is under age 65 and disabled and the group has fewer than 100 employees
d. The member has end-stage renal disease (ESRD) and it is during the 30 months after they became eligible to enroll in Medicare

A member who chose not to enroll in Medicare when first eligible or canceled Medicare after initial enrollment may have to pay any expenses not paid by the Plan.

SECTION 12. MISCELLANEOUS PROVISIONS

12.1 RIGHT TO COLLECT & RELEASE NEEDED INFORMATION

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

12.2 CONFIDENTIALITY OF MEMBER INFORMATION

Keeping a member's protected health information confidential is very important to Moda Health. Protected health information includes enrollment, claims, and medical and dental information. Moda Health uses such information internally for claims payment, referrals and authorization of services, and business operations such as case management and quality management programs. Moda Health does not sell this information. The Notice of Privacy Practices provides more detail about how Moda Health uses members' information. A copy of the notice is available on the Moda Health website by following the HIPAA link or by calling 855-425-4192.

12.3 TRANSFER OF BENEFITS

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

12.4 RECOVERY OF BENEFITS PAID BY MISTAKE

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

12.5 CORRECTION OF PAYMENTS

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

12.6 CONTRACT PROVISIONS

OEBB's benefit plan documentwith Moda Health and 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 such documents. This handbook and the benefit plan document plus any endorsements or amendments shall supersede all other communications, representations or agreements, either verbal or written between the parties. If any term, provision, agreement or condition is held by a court of competent jurisdiction to be invalid or unenforceable, the remainder of the provisions shall remain in full force and effect and shall in no way be affected, impaired or invalidated.

12.7 REPLACING ANOTHER PLAN

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

12.8 RESPONSIBILITY FOR QUALITY OF MEDICAL CARE

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

12.9 WARRANTIES

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

12.10 GUARANTEED RENEWABILITY

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

a. For nonpayment of the required premiums by OEBB
b. For fraud or intentional material misrepresentation of OEBB, or with respect to coverage of individual members, the members or their representatives
c. When the number or percentage of members is less than required by participation requirements

d. For non-compliance with the employer contribution requirements in the policy
e. When Moda Health discontinues offering and/or renewing, all of its group health benefit plans in Oregon or in a specified service area within Oregon. In order to discontinue plans under this provision, Moda Health:
    i. Must give notice of the decision to the Director of the Department of Consumer and Business Services and to all groups, associations, trusts, and discretionary groups covered by the plans
    ii. May not cancel coverage under the plans for 180 days after the date of the notice required in bullet (i) if coverage is discontinued in the entire state or, except as provided in the next subsection of this paragraph, in a specified service area
    iii. May not cancel coverage under the plans for 90 days after the date of the notice required in bullet (i) if coverage is discontinued in a specified service area because of an inability to reach an agreement with the healthcare providers or organization of healthcare providers to provide services under the plans within the service area
f. When Moda Health discontinues offering and renewing a group health benefit plan in a specified service area within Oregon because of an inability to reach an agreement with the healthcare providers or organization of healthcare providers to provide services under the plan within the service area. In order to discontinue a plan under this provision, Moda Health:
    i. Must give notice of the decision to the director and to all groups, associations, trusts, and discretionary groups, covered by the plan
    ii. May not cancel coverage under the plan for 90 days after the date of the notice required in bullet (i)
    iii. Must offer in writing to each group, association, trust, and discretionary group, covered by the plan, all other group health benefit plans that Moda Health offers in the specified service area. Moda Health shall offer the plans at least 90 days prior to discontinuation
g. When Moda Health discontinues offering and/or renewing a health benefit plan for all groups, associations, trusts, and discretionary groups in Oregon or in a specified service area within Oregon, other than a plan discontinued under the paragraph immediately above. With respect to plans that are being discontinued, Moda Health must:
    i. Offer in writing to each group, association, trust, and discretionary group covered by the plan, one or more health benefit plans that Moda Health offers in the specified service area
    ii. Offer the plans at least 180 days prior to discontinuation
    iii. Act uniformly without regard to the claims experience of the affected groups, associations, trusts, and discretionary groups of the health status of any current or prospective members
h. When the director orders Moda Health to discontinue coverage in accordance with procedures specified or approved by the director upon finding that the continuation of the coverage would:
    i. not be in the best interest of the members
    ii. impair Moda Health's ability to meet contractual obligations
i. When, in the case of a group health benefit plan that delivers covered services through a specified network of healthcare providers, there is no longer any member who lives, resides or works in the service area of the provider network

j. When, in the case of a health benefit plan that is offered in the group market only through one or more bona fide associations, the membership of an employer in the association ceases and the termination of coverage is not related to the health status of any member

12.11 NO WAIVER

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

12.12 GROUP IS THE AGENT

OEBB is the member's agent for all purposes under the Plan. OEBB is not the agent of Moda Health. Moda Health, as administrator of the Plan, is the representative of, and has authority to act for, OEBB under this handbook and the benefit plan document with Moda Health unless and until a member is otherwise notified in writing by OEBB. Where reference in this handbook is made to "the Plan" or to OEBB, such references shall include Moda Health acting in its capacity as administrator of the Plan.

12.13 COMPLIANCE WITH FEDERAL & STATE MANDATES

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

12.14 GOVERNING LAW

To the extent the Plan is governed by state law, it shall be governed by and construed in accordance with the laws of the state of Oregon. Should federal law, including but not limited to the Affordable Care Act, supersede state law and create a discrepancy between state and federal law, federal law shall govern.

12.15 WHERE ANY LEGAL ACTION MUST BE FILED

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

12.16 TIME LIMITS FOR FILING A LAWSUIT

Any legal action arising out of, or related to, the Plan and filed against the Plan, Moda Health or OEBB by a member or any third party, must be filed in court no more than 3 years after the time

the claim was filed (see section 11.1). All internal levels of appeal under the Plan must be exhausted before filing a legal action in court.

12.17 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.

SECTION 13. CONTINUATION OF HEALTH COVERAGE

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

13.1 FAMILY AND MEDICAL LEAVE

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

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

13.2 LEAVE OF ABSENCE

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

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

13.3 WORKERS' COMPENSATION

If a subscriber is no longer eligible because of a medical condition and has filed a workers' compensation claim, they may continue coverage for up to 6 months. The subscriber must pay the full premiums directly to the Group, and the Group must pay the premiums to Moda Health when due. Continuation of coverage will end early if the subscriber takes full-time employment with another employer.

13.4 STRIKE OR LOCKOUT

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

directly to the union or trust, and the union or trust must continue to pay Moda Health the premiums when due.

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

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

13.5 RETIREES

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

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

13.6.1 Introduction

Moda Health will provide 55+ Oregon Continuation coverage to those members who elect it.

Other than the inclusion of domestic partners, Moda Health will offer no greater rights than ORS 743B.343 to 743B.345 requires.

13.6.2 Eligibility

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

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

13.6.3 Notice & Election Requirements

Notice of Divorce, Dissolution, or Legal Separation. Within 60 days of legal separation or the entry of a judgment of dissolution of marriage or domestic partnership, a member who is eligible for 55+ Oregon Continuation and seeks such coverage shall give OEBB written notice of the legal separation or dissolution. The notice shall include the member's mailing address.

Notice of Death. Within 30 days of the death of the subscriber, OEBB shall give the designated third party administrator, if any, written notice of the death and the mailing address of the eligible surviving spouse or domestic partner.

Election Notice. Within 14 days of receipt of the above notice, OEBB shall provide notice to the surviving, legally separated or divorced spouse or domestic partner that coverage can be continued, along with an election form. If OEBB does not provide this election notice within the required timeframe, premiums shall be waived until the date notice is received.

Election. The surviving, legally separated or divorced spouse or domestic partner must return the election form within 60 days after the form is mailed. If the election is not made within 60 days of the notification, the member will lose the right to continued benefits under this section.

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

13.6.5 When Coverage Ends
55+ Oregon Continuation will end on the earliest of any of the following events:

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

13.7 COBRA CONTINUATION COVERAGE

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

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

For purposes of section 13.7, Plan Administrator means either OEBB or a third party administrator delegated by OEBB to handle COBRA administration.

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

13.7.2 Qualifying Events
Subscriber. A subscriber may elect continuation coverage if coverage is lost because of termination of employment (other than termination for gross misconduct), or a reduction in hours.

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

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

If it can be established that a subscriber has eliminated coverage for their spouse in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the later divorce or legal separation will be considered a qualifying event even though the ex-spouse lost coverage earlier. If the ex-spouse notifies the COBRA Administrator within 60 days of the divorce or legal separation, COBRA coverage may be available for the period after the divorce or legal separation.

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

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

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

13.7.3 Other Coverage

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

13.7.4 Notice & Election Requirements

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

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

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

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

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

13.7.5 Length of Continuation Coverage

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

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

13.7.6 Extending the Length of COBRA Coverage

An extension of the maximum period of coverage may be available if a member is disabled or a second qualifying event occurs. The Plan Administrator must be notified of a disability or a second qualifying event in order to extend the period of COBRA coverage. If the member does not provide notice of a disability or second qualifying event, they will lose the right to extend the period of COBRA coverage.

Disability. If any of the members is determined by the Social Security Administration to be disabled, the maximum COBRA coverage period that results from a subscriber's termination of employment or reduction of hours may be extended to a total of up to 29 months. The disability must have started before the 61st day of the COBRA coverage period and the Social Security Administration determination must be made before the end of the initial 18-month COBRA coverage period. Each family member who has elected COBRA coverage will be entitled to the disability extension if one of them qualifies.

The member must provide a copy of the Social Security Administration's determination of disability to the COBRA Administrator within 60 days after the latest of:

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

If the notice is not provided within this timeframe, then there will be no disability extension of COBRA coverage. The premiums for COBRA coverage may increase after the 18th month of coverage to 150% of the premium.

If the Social Security Administration determines the member is no longer disabled, the disability extension ends. The member must notify the Plan Administrator no more than 30 days after the Social Security Administration's determination that they are no longer disabled.

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

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

Note: Longer continuation coverage may be available under Oregon Law for a subscriber's spouse or domestic partner who has entered into a "Declaration of Domestic Partnership" that is recognized under Oregon law age 55 and older who loses coverage due to the subscriber's death, or due to legal separation or dissolution of marriage or domestic partnership (see section 13.6).

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

13.8 UNIFORMED SERVICES EMPLOYMENT & REEMPLOYMENT RIGHTS ACT (USERRA)

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

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

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

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

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

SECTION 14. MEMBER DISCLOSURES

14.1 What are a member's rights and responsibilities?

Members have the right to:

a. Information about the Plan and how to use it, the providers who will care for them, and their 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 their healthcare. This includes
    i. a discussion of appropriate or medically necessary treatment options, no matter how much they cost or if they are covered by Moda Health
    ii. the right to refuse treatment and be informed of the possible medical result
    iii. File a statement of wishes for treatment (i.e., an Advanced Directive), or give someone else the right to make healthcare choices when the member is 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 Moda Health
h. Make suggestions regarding Moda Health's member rights and responsibilities policy

Members have the responsibility to:

a. Read this handbook and make sure they understand the Plan. Members should call Customer Service if they have any questions.
b. Treat all providers and their staff with courtesy and respect
c. Be on time for appointments, and call the office ahead of time if they will be late or need to cancel
d. Get regular health checkups and preventive services
e. Give their provider all the information needed to provide good healthcare
f. Participate in making decisions about their medical care and forming a treatment plan
g. Follow plans and instructions for care they have agreed to with their provider
h. Use urgent and emergency services appropriately
i. Show their medical ID (identification card) when seeking medical care
j. Tell providers about any other insurance policies that may provide coverage
k. Reimburse Moda Health from any third party payments they may receive
l. Provide information the Plan needs to properly administer benefits and resolve any issues or concerns that may arise

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

14.2 What if a member has a medical emergency?

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

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

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

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

A member can file an appeal or complaint by writing a letter to Moda Health. Customer Service can help the member if needed. Complete information can be found in section 11.2.

A member may also ask for help from the Oregon Division of Financial Regulation:

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

14.5 What are the prior authorization and utilization review criteria?

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

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

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

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

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

The Plan provides benefits for mastectomy related services, including all states 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.

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

Moda Health protects members' information in several ways:

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

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

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

Moda Health has advisory committees to allow participation in the development of corporate policies and to provide feedback. Members may obtain more information by contacting Moda Health.

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

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

14.10 What additional information is available upon request?

The following documents are available free of charge by calling Customer Service:

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

14.11 What information about Moda Health is available from the Oregon Division of Financial Regulation?

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

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

Contact:

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

SECTION 15. VALUE ADDED PROGRAMS

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

15.1 WW (FORMERLY KNOWN AS WEIGHT WATCHERS)

Members can take advantage of OEBB's WW program OEBB in the format that works best for their lifestyle:

a. **Digital** – gives members 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 members 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: www.OEBBwellness.com

15.2 TOBACCO CESSATION PROGRAM

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

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

SECTION 16. DEFINITIONS

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

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

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

Approved Clinical Trial
Limited to those clinical trials 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 United States Department of Energy, the United States Department of Defense or the United States Department of Veterans Affairs
b. Conducted as an investigational new drug application, an investigational device exemption or a biologics license application to the United States Food and Drug Administration
c. Exempt by federal law from the requirement to submit an investigational new drug application to the United States Food and Drug Administration

Authorization see Prior Authorization.

Autism Service Provider means a behavior analyst licensed by the Oregon Behavior Analysis Regulatory Board (BARB), an assistant behavior analysis licensed by BARB and practicing under the supervision of a behavior analyst, an interventionist registered by BARB and practicing under the supervision of a behavior analyst, or a state-licensed or state-certified healthcare professional providing services for autism spectrum disorder within the scope of their professional license. In states that do no license autism service providers, certification or registration with the Behavior Analysis Certification Board may be accepted instead.

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

Balance Billing means the difference between the maximum plan allowance and the provider's billed charge. Out-of-network providers may bill the member this amount, except Oregon-licensed providers when performing services at an in-network facility and the member did not choose the provider. Balance billing is not a covered expense under the Plan.

Behavioral Health Assessment means an evaluation by a behavioral health provider, in person or using telemedicine, to determine a person's need for immediate crisis stabilization.

Behavioral Health Crisis means 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.

Chemical Dependency means an addictive physical and/or psychological relationship with any drug or alcohol that interferes on a recurring basis with an individual's main life areas, such as employment, and psychological, physical and social functioning. Chemical dependency does not mean an addiction to or dependency upon foods, tobacco, or tobacco products.

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

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

Coordinated Specialty Program means:

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)

These programs provide multidisciplinary, team-based care to individuals with mental health conditions and their families. Programs must operate under a Certificate of Approval from the Oregon Health Authority to qualify.

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

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

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

Custodial Care means care that helps a member conduct such common activities as bathing, eating, dressing, 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.

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

Disease Management Program for Pain means a holistic, organized course of treatment to help individuals manage chronic pain. Programs incorporate assessment, education, movement therapy and mindfulness training to change the experience of pain and help individuals with chronic pain improve their functioning.

Emergency Medical Condition means 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 of a member, or a fetus in the case of a pregnant member, in serious jeopardy without immediate medical attention.

Emergency Medical Screening Examination means 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.

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

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

Experimental or Investigational means services and supplies 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
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

Experimental or Investigational Medications are those that involve one or more of the following:

a. A medication, device (supply) or biologic product for which the approval of one or more government agencies (such as the FDA) is required, but has not been obtained at the time the treatment is requested or administered
b. A treatment for which scientific or medical assessment has not been completed, or the effectiveness of the treatment has not been generally established
c. Is only available in the United States as part of a clinical trial or research program for the illness or condition being treated

d. Is the subject of an on-going phase I or phase II clinical trial, or is the research/ experimental/study/investigational arm of an on-going phase III clinical trial
e. Is used within a regimen that may be individually proven, but when utilized in combination, scientific literature does not support the use
f. Is used within a regimen that is proven in combination with other medications, but when utilized individually, scientific literature does not support the use

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

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

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

Hearing Assistive Technology Systems means devices that amplify or change audio communication to another format or alert members where there is a lot of background noise. Examples include frequency modulation (FM), infrared systems, induction loop systems, telephone amplifiers, voice carryover telephones, text telephones or alerting devices.

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

Implant means a material inserted or grafted into tissue.

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

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

Intensive Outpatient means mental health or chemical dependency services 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. Chemical dependency intensive outpatient is 9-19 hours per week for adults or 6-19 hours per week for adolescents.

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

MPA for out-of-network services is either a supplemental provider fee arrangement Moda Health may have in place or the amount calculated using one of the following methodologies, any of which may be used by Moda Health: 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. Otherwise, the MPA is the amount determined by state guidelines.

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

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

In certain instances, when a dollar amount is not available, Moda Health reviews the claim to determine a comparable code to the one billed. Once a comparable code is established, the claim is processed as described above.

When using an out-of-network provider, any amount above the MPA may be the member's responsibility (this is the balance billing amount).

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

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

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

a. It is consistent with the symptoms or diagnosis of a member's condition and appropriate considering the potential benefit and harm to the patient
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.

Moda Health may require proof that services, interventions, supplies or medications (including court-ordered care) are medically necessary. No benefits will be provided 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 proof of medical necessity is required but not provided by the health service provider.

Medically necessary care does not include custodial care.

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

More information about medical necessity can be found in General Exclusions (Section 8).

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

Mental Health refers to benefits, facilities, programs, levels of care and services related to the assessment and treatment of mental health conditions, as defined below.

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

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

Moda Health refers to Moda Health Plan, Inc.

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

Network means a group of providers who contract to provide healthcare to members at negotiated rates. Such groups are called Preferred Provider Organizations (PPOs), and provide in-network services in their specific service areas. Covered medical expenses will be paid at a higher rate when an in-network provider is used (see Section 3).

OEBB means the Oregon Educators Benefit Board.

Out-of-Network refers to providers that are not contracted under Moda Health to charge discounted rates to members.

Out-of-Pocket Maximum means the maximum amount a member pays out-of-pocket every plan year, including the deductible, coinsurance and copays other than additional cost tier copayments. If a member obtains both in-network and out-of-network services, 2 separate out-of-pocket maximums apply. If a member reaches the out-of-pocket maximum in a plan year, the Plan will pay 100% of eligible expenses for the rest of the year. Member's cost sharing for prescription benefits and additional cost tier payments does not apply to the out-of-pocket maximum.

Outpatient Surgery means surgery that does not require an inpatient admission or a stay of 24 hours or more.

Partial Hospital Program means an appropriately licensed mental health or chemical dependency facility providing no less than 4 hours of direct, structured treatment services per day. Chemical dependency partial hospital programs provide 20 or more hours of direct treatment per week. Partial hospital programs do not provide overnight 24-hour per day care.

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 and use a PCP 360 to receive the enhanced benefits of coordinated care (see section 5.2).

The **Plan** is the health benefit plan sponsored by OEBB and offered through a minimum premium arrangement under the terms of the policy between OEBB and Moda Health.

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

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

Prior Authorization or **Prior Authorized** refers to obtaining approval by Moda Health before the date of service. A complete list of services and medications that require prior authorization is available on the Member Dashboard or by contacting Customer Service. Failure to obtain required authorization will result in denial of benefits (see section 6.1).

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

Provider means 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 to a member.

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

Respite Care means care for a period of time to provide caregivers relief from full-time residing with and caring for a member in hospice. Providing care to allow a caregiver to return to work does not qualify as respite care.

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

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

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.

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

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

For help, call us directly at 866-923-0409.
(En Español: 888-786-7461)

P.O. Box 40384
Portland, OR 97240