2024

Oregon Group Medical Plan

Multnomah County
PPO 400 Plan
Classes: 0001, 0002, 0003, 0004, 0005, 0006, 0007, 0008, 0009, 0010, 0011, 0013, 0014 and 0015

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January 1, 2024

Multnomah County

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

moda HEALTH

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SECTION 1. WELCOME TO MODA HEALTH

The Plan is self-funded. This means money that pays your claims comes from the Group. We are pleased that Multnomah County (also known as the Group) has chosen Moda Health to provide claims and other administrative services. Where this book talks about Moda Health as paying claims, it means that we are issuing benefits that the Group is providing (paying).

The Plan is funded by the Group and/or subscriber contributions. The amount of total contributions is determined from time to time by the use of sound actuarial and underwriting methods. The portion you pay toward the total contribution is determined by the Group and your bargaining unit.

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

The Group may change or replace this handbook at any time without your agreement. You can find the most current handbook on your Member Dashboard. All plan provisions are governed by the Group's agreement with Moda Health. This handbook may not contain every plan provision. It does not waive any of the conditions of the Plan as stated in the Plan document.

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

SECTION 2. MEMBER RESOURCES

2.1 CONTACT INFORMATION

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

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

- Find an in-network provider with Find Care
- See if a service or supply you need must be prior authorized first (Referral and Authorization link under Resources)

Medical Customer Service Department
1-888-445-7413
En español 888-786-7461

Behavioral Health Customer Service Department
833-212-5027

Disease Management and Health Coaching
855-466-7155

Hearing Services preferred vendor
TruHearing
866-202-2178

Virtual Care preferred vendor
CirrusMD
modahealth.com/cirrusmd

Pharmacy Customer Service Department
WellDyne Member Services 1-888-479-2000
Pharmacy Help Desk 1-888-886-5822
US Specialty Pharmacy 1-800-641-8475

Vision Care Customer Service
www.vsp.com
Vision Service Plan (VSP) 1-800-877-7195

Medical Telecommunications Relay Service for the hearing impaired
711

Pharmacy Telecommunications Relay Service for the hearing impaired
1-800-900-6570

VSP Telecommunications Relay Service for the hearing impaired
1-800-428-4833

Employee Assistance Program (EAP)
866-483-1493; mention you are a Multnomah County employee, dependent or household member
Website: ComPsych
Web ID: MultCo

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

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

Vision Service Plan (VSP)
3333 Quality Drive
Rancho Cordova, CA 95670

WellDyneRx
P.O. Box 3129
Englewood, CO 80155

2.2 MEMBER ID CARD

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

2.3 NETWORKS

This Plan pays in-network benefits only for services provided in the networks shown below. Network Information (Section 5) explains how networks work. These are the networks for your Plan.

Medical network
Connexus

If the subscriber lives outside the service area, the network is based on where they live:

a. Alaska: Endeavor Select, with service area in Alaska
b. Idaho: Connexus, with service area in Idaho and FirstHealth nationwide
c. Nationwide: Aetna PPO, with service area in most states other than Alaska, Idaho, Oregon and southwest Washington

Pharmacy network
WellDyneRx

Vision Care network
VSP Choice Network

Travel network
Aetna PPO

2.4 CARE COORDINATION

2.4.1 Care Coordination

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

2.4.2 Disease Management & Health Coaching

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

2.4.3 Behavioral Health

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

2.5 OTHER RESOURCES

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

SECTION 3. SCHEDULE OF BENEFITS

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

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

You will find details of the actual benefits in the sections after this summary. You will need to know the conditions, limitations and exclusions of the Plan that are explained there. **Benefits are paid based on a PLAN YEAR – January through December.** Prior authorization may be required for some services (see Section 6). Important terms are explained in Section 12.

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

When a benefit has an "annual" or "per year" limit, it will accrue on a plan year (from January 1st to December 31st) basis unless otherwise specified.

	In-Network Benefits	Out-of-Network Benefits
Annual deductible per member	**$400**	
Maximum annual deductible per family	**$1,200**	
Annual medical out-of-pocket maximum per member (includes deductible and does not include prescription out of pocket costs)	**$2,000**	
Annual medical out-of-pocket maximum per family (includes deductible and does not include prescription out of pocket costs)	**$6,000**	
Annual prescription out-of-pocket maximum per member (includes value, select, preferred and non-formulary medications)	**$2,000**	
Annual prescription out-of-pocket maximum per family (includes value, select, preferred and non-formulary medications)	**$6,000**	

Services	Amount You Pay		Section in Handbook & Details
	In-network	Out-of-network	
Urgent & Emergency Care			
Ambulance Transportation	15% after deductible		Section 7.2.1
Emergency Room Facility (includes ancillary services)	$100 per visit, then 15% after deductible		Section 7.2.2 No copay if admitted to hospital from emergency room
ER professional / ancillary services billed separately	15% after deductible		

Services	Amount You Pay		Section in Handbook & Details
	In-network	Out-of-network	
Urgent Care Office Visit	$40 per visit	35% after deductible	Section 7.2.3
Preventive Services			
Services as required under the Affordable Care Act, including:	0%	35%	Section 7.3
Colonoscopy	0%	35%	Section 7.3.1 One per 10 years, age 45+
Contraception	0%	35%	Section 7.3.2
Immunizations	0%	0%	Section 7.3.3
Mammogram	0%	35% after deductible	Section 7.3.8 One per year, age 40+
Pediatric Screenings	0%	35%	Section 7.3.4 Age/frequency limits apply
Preventive Health Exams	0%	35%	Section 7.3.5 6 visits in first year of life 7 exams from age 1 to 4 One per year, age 5+
Preventive X-ray & Lab	0%	35%	Section 7.4.11
Tobacco Cessation Treatment			Section 7.3.7 Prescriptions may be purchased at any pharmacy
Consultation	0%	0%	
Supplies			
Prescription Medications			
Well Baby Exams	0%	35%	Section 7.3.5
Women's Exam & Pap Test	0%	35% after deductible	Section 7.3.8 One per year
Other preventive services, including:			
Screening X-ray & Lab	15%	35%	Section 7.4.11
Prostate Rectal Exam	0%	35%	Section 7.3.6 Once every 2 years, age 50+
Prostate Specific Antigen (PSA) Test	0%	35%	
General Treatment Services			
Acupuncture	15% after deductible	35% after deductible	Section 7.4.1 20 visits per year
Anticancer Medication	20%, up to $50 maximum after deductible	20%, up to $50 maximum after deductible	Section 7.4.2
Applied Behavior Analysis	15% after deductible	35% after deductible	Section 7.4.3

Services	Amount You Pay		Section in Handbook & Details
	In-network	Out-of-network	
Behavioral Health Services		35% after deductible	Section 7.4.4
Detoxification (Detox)	15% after deductible		
Office Visits	0%		
Intensive Outpatient			
Other Outpatient Services	15% after deductible		
Coordinated Specialty Programs	0%		
Inpatient	15% after deductible		
Partial Hospitalization			
Residential Treatment Program			
Biofeedback	$40 per visit	35% after deductible	Section 7.4.5 10 visits lifetime maximum
Dental Injury	15% after deductible	35% after deductible	Section 7.4.9
Diabetes Services			Section 7.4.10 Supplies covered under DME benefits
Diabetes Self-Management Programs (including pre-diabetes condition)	0%	0%	
Other medical services	15% after deductible	35% after deductible	
Diagnostic Procedures, including x-ray and lab		35% after deductible	Section 7.4.11 In-network HgA1c and Cholesterol LDL, HDL and Triglycerides lab work related to chronic condition management (asthma, heart disease, high blood pressure, diabetes & high cholesterol) will be covered at no cost share.
Chronic condition lab work	0%		
Other Outpatient	15% after deductible		
Inpatient	15% after deductible		
Advanced Imaging	15% after deductible		
Disease Management for Pain	0%	35% after deductible	Section 7.4.12
Durable Medical Equipment (DME) Supplies & Appliances	15% after deductible	35% after deductible	Section 7.4.13
Wigs	15% after deductible	35% after deductible	Section 7.4.13 One per year
Hearing Aids & Related Services for Members 26+			Section 7.4.15
Exam	15%	35% after deductible	One per plan year
Other Services	50%	50% after deductible	$4,000 maximum every 48 months

Services	Amount You Pay		Section in Handbook & Details
	In-network	Out-of-network	
Hearing Aids & Related Services (Mandated Benefits for Members under age 26)			Section 7.4.17 Age/frequency limits apply
Exam	15%	15% after deductible	
Other Services	15%	35% after deductible	
Home Healthcare	15% after deductible	35% after deductible	Section 7.4.18 60 visits per year
Hospice Care			Section 7.4.19
Home Care	0%	35% after deductible	
Inpatient Care	0%	35% after deductible	
Respite Care	0%	35% after deductible	
Hospital Inpatient Care	15% after deductible	35% after deductible	Section 7.4.20
Hospital Physician Visits	15% after deductible	35% after deductible	Section 7.4.21
Infertility Diagnosis	15% after deductible	35% after deductible	Section 7.4.23 $10,000 lifetime limit
Infusion Therapy (Home or Outpatient)	15% after deductible	35% after deductible	Section 7.4.24 Some medications may be limited to certain providers or settings.
Kidney Dialysis	15% after deductible	35% after deductible	Section 7.4.25
Massage Therapy	50%	50%	Section 7.4.26 12 visits per year
Naturopathic Supplies	50%	50%	Section 7.4.29
Office and Home Visits			Section 7.4.32 See also Virtual Care Visits Naturopathic physicians are considered specialists unless credentialed as a PCP In-network copay is waived for PCP or specialist visits related to management of these chronic conditions: asthma, heart disease, high blood pressure, diabetes, high cholesterol & behavioral health.
PCP visits	$20 per visit	35% after deductible	
Specialist visits	$40 per visit		

Services	Amount You Pay		Section in Handbook & Details
	In-network	Out-of-network	
Rehabilitation & Habilitation (Physical, occupational and speech therapy)		35% after deductible	Section 7.4.35 Rehabilitation up to 60 outpatient sessions per year. Habilitation only covered outpatient, for mental health conditions. Inpatient confinement must begin within one year of onset of the condition
Outpatient	15% after deductible		
Inpatient	15% after deductible		
Skilled Nursing Facility Care	15% after deductible	35% after deductible	Section 7.4.36 100 days per year
Spinal Manipulation	50%	50%	Section 7.4.37 20 visits per year
Surgery and Invasive Diagnostic Procedures		35% after deductible	Section 7.4.38
Outpatient	15% after deductible		
Inpatient	15% after deductible		
Temporomandibular Joint Syndrome (TMJ)	15% after deductible	35% after deductible	Section 7.4.39 $1,500 lifetime maximum
Therapeutic Injections	15% after deductible	35% after deductible	Section 7.4.40
Therapeutic Radiology	15% after deductible	35% after deductible	Section 7.4.41
Transplants			Section 7.4.42
Center of Excellence facilities	15% after deductible	N/A	
Other facilities	Not covered	Not covered	
Donor Costs			Section 7.4.42
Center of Excellence facilities	15% after deductible	N/A	
Other facilities	Not covered	Not covered	
Virtual Care Visits			Section 7.4.43
Through CirrusMD	$0	N/A	Log on via modahealth.com/cirrusmd
Other providers	$20 per visit	35% after deductible	In-network copay is waived for visits related to management of these chronic conditions: asthma, heart disease, high blood pressure, diabetes, high cholesterol & behavioral health.

Services	Amount You Pay		Section in Handbook & Details
	In-network	Out-of-network	
Maternity Services			
Breastfeeding			Section 7.5.2
Support and Counseling	0%	35% after deductible	
Supplies		0%	
Maternity	15% after deductible	35% after deductible	Section 7.5
Newborn Home Visiting Program	0%	Not covered	Section 7.5.5 Visit limits apply
Pharmacy			
Prescription Medications	Prescription drug benefits are administered by WellDyneRx		Section 7.6 No deductible
Retail Pharmacy			Up to 30-day supply $85 max cost share for insulin
Value Tier	20%, up to $4 maximum		
Tier 1 Select	20%, up to $50 maximum		
Tier 2 Preferred	20%, up to $50 maximum		
Tier 3 Non-Formulary	50%		
Mail Order Pharmacy			Up to 90-day supply per prescription $255 max cost share for insulin
Value Tier	20%, up to $8 maximum	Mail-order prescriptions required to be filled in-network	
Tier 1 Select	20%, up to $30 maximum		
Tier 2 Preferred	20%, up to $125 maximum		
Tier 3 Non-Formulary	50%		
Specialty Pharmacy			Up to 30-day supply $85 max cost share for insulin
Tier 1 Select	20%, up to $50 maximum	Exclusive pharmacy only	
Tier 2 Preferred	20%, up to $50 maximum		
Tier 3 Non-Formulary	50%		
Anticancer Medication	20%, up to $50 maximum		Section 7.4.2 No deductible
Vision			
Vision care and treatment of the eye			
Routine exam and hardware	See separate VSP schedule	See separate VSP schedule	Section 7.7
Other medically necessary treatment and supplies related to the eye covered under the medical benefits. Some common services include:			Refer to the applicable types of services such as office visits, diagnostic procedures, prosthetics, etc.

Services	Amount You Pay		Section in Handbook & Details
	In-network	Out-of-network	
Eyewear after cataract surgery	15% after deductible	35% after deductible	Section 7.4.13
Eyewear for the diagnoses of aphakia or keratoconus	15% after deductible	35% after deductible	Section 7.4.13
Annual dilated eye exam or retinal imaging for diabetes screening	15% after deductible	35% after deductible	Section 7.4.13

SECTION 4. PAYMENT & COST SHARING

4.1 MEDICAL DEDUCTIBLES

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

Disallowed charges, copayments, prescription drug out-of-pocket expenses, and manufacturer discounts and/or copay assistance programs do not count toward your annual deductible.

If you have covered expenses in the last 3 months of the calendar year that count toward your deductible for that year, they will also be carried forward and applied to your deductible for the following year.

If a new division of employees is added to the Group during a plan year, any medical deductible amount satisfied under the division's prior policy, during the year, will be credited under the Plan.

Common Accident Benefit: If more than one member in a family unit incurs covered medical expenses as a result of injuries suffered in a common accident, then the accident-related covered expenses for these members in the family will be subject to only one medical deductible each year.

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

4.2 MAXIMUM OUT-OF-POCKET

The Plan helps protect you from very high medical costs. The out-of-pocket maximum is an upper limit on how much you have to pay for covered charges each year. Once you have paid the maximum amount, the Plan will pay 100% of covered services for the rest of the year. If more than one member of your family is covered, the per member maximum applies only until the total family out-of-pocket maximum is reached, even if no single family member has reached the per member maximum. Covered services, whether you get them in-network or out-of-network, count toward your out-of-pocket maximum.

The Plan has a separate out-of-pocket maximum for pharmacy expenses (shown in Section 3). Once you have paid your pharmacy out-of-pocket maximum amount, your covered prescriptions will be paid at 100%.

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

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

a. Expenses for hearing aids if you are age 26 and older
b. Extra expenses you pay when you use a brand medication when a generic is available
c. Penalties because your care was not prior authorized
d. Disallowed charges

4.3 PAYMENT

The Plan is self-funded. This means money that pays your claims comes from the Group. Moda Health provides claims and other administrative services. Where this book talks about Moda Health paying claims, it means that we are issuing benefits that the Group is providing (paying).

Covered expenses are paid based on the contracted fees for services rendered by in-network providers and the maximum plan allowance (MPA). The MPA is defined in Section 12. You may have to pay some of the charges (cost sharing). What you have to pay depends on the Plan provisions.

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

4.4 EXTRA-CONTRACTUAL SERVICES

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

After case evaluation and analysis by Moda Health, Moda Health will contact the Group and make a recommendation on whether extra-contractual services are medically necessary and appropriate. Extra-contractual services will be covered when the Group, and you and your professional provider, agree. Any of us can end these services by giving notice in writing.

Payment of extra-contractual services not otherwise covered by the Plan shall be at the sole discretion of Moda Health with the Group's approval based on evaluation of the individual case. The fact that the Plan has paid benefits for extra contractual services for a member does not obligate it to pay such benefits for any other member, nor does it obligate the Plan to pay benefits for continued or additional extra-contractual services for the same member. Extra-contractual benefits paid under this provision will be included in calculating any benefits, limitations or cost sharing under the Plan.

SECTION 5. NETWORK INFORMATION

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

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

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

5.1 GENERAL NETWORK INFORMATION

5.1.1 Network and Service Area

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

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

Networks
Medical network is Connexus, with providers in Oregon, southwest Washington and Idaho counties that border Oregon
Pharmacy network is WellDyneRx
Vision care network is VSP Choice Network

For members if subscribers live outside the Connexus service area:

Where the subscriber lives	Network name	Network service area
Alaska	Endeavor Select	Alaska
Idaho	Connexus	These Idaho counties: Adams, Bannock, Bingham, Boise, Canyon, Caribou, Elmore, Gem, Minidoka, Oneida, Owyhee, Payette, Power and Washington; and Oregon and southwest Washington
	FirstHealth	Nationwide
Other States	Aetna PPO	Nationwide

You may only use the networks listed in the table above and receive the in-network level of benefits if the subscriber lives outside the Connexus service area. If the subscriber lives in the Connexus service area, you will receive out-of-network benefits if you use any of the other networks listed above.

5.1.2 Out-of-Area Network for Dependents

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

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

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

Out-of-Area Network
Aetna PPO

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

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

5.1.3 Travel Network

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

You may only use a travel network provider if:

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

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

Travel Network
Aetna PPO

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

5.1.4 Out-of-Network Care

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

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

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

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

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

5.1.5 Care after Normal Office Hours

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

5.2 USING FIND CARE

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

5.2.1 DME Providers

Find a preferred DME provider for savings on your DME:

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

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

SECTION 6. PRIOR AUTHORIZATION

The following prior authorization provisions may affect how medical benefits are paid.

Possible Penalties
Benefits will be reduced by $100.00 if you do not obtain prior authorization for inpatient, residential (including intensive outpatient treatment), or mandatory second surgical opinion provisions. The $100.00 penalty does not apply towards the Plan's deductible or out-of-pocket maximum.

6.1 PRIOR AUTHORIZATION REQUIREMENTS FOR MEDICAL PLAN COVERAGE

For prior authorization for pharmacy services, contact WellDyneRx.

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

a. If services will be rendered by an out-of-network provider, you must initiate a request to Moda Health for prior authorization.
b. If services will be rendered by an in-network provider, your provider will initiate a request to Moda Health for prior authorization.

We must receive a completed prior authorization form. We will either approve the procedure or admission and when applicable, assign the expected length of stay and an appropriate time of admission (such as the morning of, or the night before, a scheduled surgery), ask for additional information and/or request that you get a second opinion. We may also specify that you receive care on an outpatient basis only. The hospital, professional provider and you are notified of the outcome of the authorization process by letter.

Prior authorization does not guarantee coverage. When a service is not medically necessary, or is otherwise excluded from benefits, charges will be denied. For example, services receiving prior authorization but rendered after your termination of coverage would be denied.

Most services require prior authorization and are subject to financial penalty for failure to comply with the prior authorization requirement.

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

6.1.1 Inpatient Services and Residential Programs

In order for maximum plan benefits to be paid, prior authorization is required for all non-emergency hospital confinements that are scheduled in advance and for admission to any residential treatment program. If the hospital or residential stay is not medically necessary, claims will be denied. We will authorize medically necessary lengths of stay based upon the

medical condition. Additional hospital or residential days are covered only upon medical evidence of need.

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

6.1.2 Ambulatory/Outpatient Surgery and Other Outpatient Services

Prior authorization must be obtained for any inpatient admission or overnight stay for a service that is commonly performed on an outpatient basis. Other outpatient or ambulatory services also require prior authorization. Any covered benefit will be based on the cost of the most appropriate setting for the procedure. **Failure to obtain required prior authorizations may result in denial of benefits or payment at the out-of-network benefit level.**

6.1.3 Imaging Procedures

Prior authorization for advanced imaging services is required. If authorization is not obtained ***in advance*** of receiving such services, the charges will be denied.

In-network providers who perform advanced imaging services are responsible for obtaining prior authorization on your behalf. If you are using an out-of-network provider, you are responsible for ensuring that your provider contacts Moda Health for prior authorization. ***Services not authorized in advance will be denied.*** An in-network provider is expected to write off the full charge of denied imaging services that are performed without proper prior authorization. If the provider is out-of-network, denied charges for imaging procedures not authorized will be ***your full financial responsibility*****.**

6.1.4 Prior Authorization Limitations

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

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

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

6.1.5 Second Opinion

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

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

SECTION 7. BENEFIT DESCRIPTION

The Plan covers services and supplies described in this handbook when they are medically necessary to diagnose and/or treat a medical condition, or are preventive services. We explain the benefits and the conditions, limitations and exclusions in the following sections. An explanation of important terms is in Section 12. Prescription medications and vision care are covered by separate plans (see sections 7.6 and 7.7).

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

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

7.1 WHEN BENEFITS ARE AVAILABLE

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

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

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

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

7.2 URGENT & EMERGENCY CARE

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

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

7.2.1 Ambulance Transportation

Medically necessary ground or air ambulance transport, or secure transport, to the nearest facility that is able to provide the treatment you need is covered. We will not pay any more for air ambulance than we would have for a ground ambulance. Ambulance providers are usually out-of-network. Out-of-network ground ambulance providers may balance bill you.

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

7.2.2 Emergency Room Care ($100 Copay)

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

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

If you are admitted to the hospital immediately after emergency services, you will not have to pay the emergency room facility copayment. You will still need to pay any cost sharing for the hospital and other charges. The $100 emergency care copayment does not apply to the medical deductible, but will apply to the medical out of pocket maximum.

Prior authorization is not needed for emergency medical screening exams or treatment to stabilize an emergency medical condition.

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

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

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

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

7.2.3 Urgent Care

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

7.3 PREVENTIVE SERVICES

Under the Affordable Care Act (ACA), certain services are covered at no cost to you when you get the care from an in-network provider (see Section 3 for benefit level when services are provided out-of-network). Coverage limitations are based on reasonable medical management techniques

where permitted by the ACA. This means that you may have member cost sharing for some alternatives in the services listed below:

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

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

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

7.3.1 Colorectal Cancer Screening

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

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

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

Anesthesia that is medically necessary for colorectal cancer screening is covered under the preventive benefit. If the anesthesia is determined not medically necessary, it is not covered. For example, general anesthesia may not be medically necessary for some screenings when sedation is more appropriate.

7.3.2 Contraception

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

7.3.3 Immunizations

Routine immunizations are limited to those recommended by the ACIP. Some common immunizations include:

a. Flu shots – covered for all ages and up to 2 shots per year for age 19 and above
b. Pneumonia vaccine – covered for all ages and up to 3 shots per year for age 19 and above
c. Shingles vaccine – 2 shots of Shingrix for age 50 and above and 1 shot of Zostvax for age 60 and above per year

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

7.3.4 Pediatric Screenings

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

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

7.3.5 Preventive Health Exams

Covered according to the following schedule:

a. Newborn: One hospital exam at birth and circumcision in the hospital. If circumcision is not performed during the birth hospitalization but is performed within 3 months of the infant's birth, expenses will be covered, subject to the standard cost sharing
b. Infants: 6 well-baby visits during the first year of life
c. Age 1 to 4: 7 exams
d. Age 5 and older: One exam every year

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

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

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

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

7.3.7 Tobacco Cessation

The Plan will waive the deductible and pay 100% of covered expenses. Covered expenses include counseling, office visits, and medical supplies provided or recommended by a tobacco cessation program or other professional provider. Recommended medications are covered under a separate plan (see section 7.6).

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

7.3.8 Women's Healthcare

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

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

7.4 GENERAL TREATMENT SERVICES

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

7.4.1 Acupuncture

Covered acupuncture services are short-term in nature with the expectation that your condition will improve in a reasonable and generally predictable period of time. A limited number of visits are covered each year. Additional acupuncture treatment may be covered by the Plan upon review by us for medical necessity. Other services you may get at an acupuncture visit, such as office visits or lab and diagnostic services are not covered under this benefit. They are paid under the Plan's standard benefit for the type of service. Office visits by acupuncturists are specialist office visits.

7.4.2 Anticancer Medication

Prescribed anticancer medications, including oral, intravenous (IV) or injected medications, are covered. Most anticancer medications need to be prior authorized and have specific benefit limitations. For some anticancer medications, you may have to enroll in programs to help make sure the medication is used correctly and/or lower the cost of the medication. You can find more information on your Member Dashboard or by contacting Moda Health Customer Service. For prescription medication expenses contact WellDyneRx Customer Service (see section 7.6).

7.4.3 Applied Behavior Analysis (ABA)

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

Examples of what we do not cover:

a. Services provided by your family or household members
b. Custodial or respite care, equine assisted therapy, creative arts therapy, wilderness or adventure camps, music therapy, neurofeedback, chelation or hyperbaric chamber

c. Services provided under an individual education plan (IEP) to comply with the Individuals with Disabilities Education Act
d. Services provided by the Department of Human Services or Oregon Health Authority, except this Plan if it is your employee benefit plan offered by the Department or the Authority

7.4.4 Behavioral Health

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

Intensive outpatient mental health treatment and TMS must be prior authorized. Coordinated specialty programs must be prior authorized or authorized as soon as reasonably possible after you start them. See section 7.4.11 for coverage of diagnostic services.

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

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

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

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

Mental Health

These services by a mental health provider are covered:

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

Coordinated Specialty Programs

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

Coordinated specialty programs are:

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

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

Substance Use Disorder Services

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

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

7.4.5 Biofeedback

Biofeedback therapy services are only covered to treat tension or migraine headaches. There is a lifetime limit to how many visits we will cover. Expenses for biofeedback therapy for other diagnostic conditions or in excess of the lifetime limit are not covered.

7.4.6 Child Abuse Medical Assessment

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

7.4.7 Clinical Trials

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

The Plan does not cover items or services:

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

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

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

7.4.8 Collagen Treatment and Lipodystrophy Treatment

Collagen treatment and lipodystrophy treatment for facial wasting are covered with an HIV/AIDS diagnosis. The benefits are subject to the deductible and covered at standard in-network and out-of-network benefit levels. Requests for services are subject to review based on the criteria below:

a. Dermal filler injections are indicated for all the following conditions:
    i. diagnosis of human immunodeficiency virus (HIV)
    ii. diagnosis of facial lipodystrophy/lipoatrophy, grades 3-4, related to HIV or highly-active antiretroviral therapy (HAART)
    iii. diagnosis of depression secondary to the physical stigma of facial lipodystrophy
b. The dermal filler is approved by the Food and Drug Administration (FDA) for Facial Lipodystrophy Syndrome (LDS), e.g., Sculptra and Radiesse
c. Treatment site may include buttocks if medically necessary

7.4.9 Dental Injury

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

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

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

If you choose to have tooth implant placement as the restoration choice following a covered dental accident, the allowed amount will be limited to that which would have been allowed for a crown, bridge or partial. Removal of tooth implants or attachments to tooth implants is not covered. (Dental implants may be covered as a dental expense under your dental plan.)

7.4.10 Diabetes Services

Insulin, glucometers, pumps and other diabetic testing supplies are covered under the pharmacy benefit (section 7.6), when you buy them from a pharmacy with a valid prescription. Members can get a free One Touch Meter by calling 888-883-7091 and providing the order code 739WDRX01. Glucometers, continuous glucose monitors, pumps and other supplies are covered

under the DME benefit (section 7.4.13) when billed by a doctor. You may save more if you buy them using pharmacy benefits.

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

a. HbA1c lab test
b. Checking for kidney disease
c. Annual dilated eye exam or retinal imaging, including one by an optometrist or ophthalmologist
d. Diabetes self-management programs
    i. One diabetes assessment and training program after you are diagnosed with diabetes
    ii. Up to 3 hours of assessment and training following a change of your condition, medication or treatment, when you get it from a program or provider with expertise in diabetes
e. Dietary or nutritional therapy
f. Routine foot care (see section 7.4.33)

7.4.11 Diagnostic Procedures

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

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

In-network HgA1c and Cholesterol LDL, HDL and Triglycerides lab work related to chronic condition management (asthma, heart disease, high blood pressure, diabetes & high cholesterol) are covered at no cost sharing when billed with a chronic condition diagnosis.

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

7.4.12 Disease Management for Pain

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

7.4.13 Durable Medical Equipment (DME), Supplies & Appliances

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

Some examples of covered DME, supplies and appliances are:

a. CPAP for sleep apnea
b. Glasses or contact lenses, only if you have aphakia or keratoconus
c. Hospital beds and accessories
d. Ice therapy equipment and accessories after surgery

e. Insulin pumps, glucometers, continuous glucose monitors and other diabetes supplies (see section 7.4.10)
f. Intraocular lenses within 90 days of cataract surgery
g. Light boxes or light wands only when treatment is not available at a provider's office
h. Orthotics, orthopedic braces, orthopedic shoes to restore or maintain your ability to do day to day activities or perform your job. If you can get the correction or support you need by modifying a mass-produced shoe, then we will only cover the cost of the modification.
i. Oxygen and oxygen supplies
j. Prosthetics: The first extremity prosthesis after loss of a body part is covered, including artificial eye(s) and post-mastectomy bra and prosthetic. The Plan will cover 2 post-mastectomy bras or camisoles in a 12-month period and one prosthetic per side in a 24-month period. An additional prosthesis may be authorized if the attending professional provider provides documentation to us that a new prosthetic device is medically necessary because of changing fit or poor function.
k. Shoe Insert Orthotics: Specially made shoe insert orthotics are covered. The Plan will cover one pair every 24 months. For members under age 21, the Plan may allow more frequently upon review.
l. Wig: A wig is covered once per plan year when necessary for hair loss resulting from chemotherapy or radiation therapy.
m. Wheelchair or scooter (including maintenance expenses)

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

We encourage you to use a preferred DME provider. You may save money when you do. You can find a preferred provider using Find Care on your Member Dashboard (see section 5.2.1). Change your recurring prescription or automated billing to a preferred DME provider by contacting your current provider and the preferred DME provider and asking for the change.

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

Exclusions
In addition to the exclusions listed in Section 8, we will not cover the following appliances and equipment, even if they relate to a covered condition:
a. Those used primarily for comfort, convenience, or cosmetic purposes
b. Those used for education or environmental control (examples under Personal Items in Section 8)
c. Therapeutic devices, except for transcutaneous nerve stimulators (TENS unit)
d. Dental appliances and braces
e. Incontinence supplies
f. Supporting devices such as corsets or compression/therapeutic stockings, except when such devices are medically necessary
g. Testicular prostheses
h. Toupees

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

7.4.14 Gender Confirming Services

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

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

Covered services may include:

a. Mental health
b. Hormone therapy (including puberty suppression therapy for adolescents)
c. Surgical procedures (see section 7.4.38) such as:
    i. Breast/chest surgery
    ii. Gonadectomy (hysterectomy/oophorectomy or orchiectomy)
    iii. Reconstruction of the genitalia
    iv. Gender confirming facial surgery

7.4.15 Hearing Examinations and Testing & Hearing Aids – Benefit For Members Age 26 and Older

Hearing tests, hearing aid checks and aided testing are covered once per plan year at standard in-network and out-of-network benefit levels. Deductible is waived if you see an in-network provider. Once every 48 months, the Plan pays 50% of covered expenses for hearing aids up to a maximum of $4,000. Hearing aids require a written prescription by an audiologist or a physician and prior authorization is required.

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

7.4.16 Hearing Examinations and Testing – Benefit For Members Up to Age 26

A newborn hearing screening (screening for hearing loss in all newborn infants) is covered at no cost sharing. Subsequent hearing tests, hearing aid checks and aided testing are covered twice per plan year if you are under age 4 and once per plan year if you are age 4 to 26 at 85%.

7.4.17 Hearing Services for Members – State of Oregon Mandated Benefit

We cover these items once every 3 years for members under age 26:

a. One hearing aid per hearing impaired ear
b. Repairs, servicing or alteration of the hearing aid equipment
c. Bone conduction sound processors, if necessary for appropriate amplification and prior authorized (the surgery to install the implant is covered at the surgical benefit level)
d. Hearing assistive technology system, if necessary for appropriate amplification and prior authorized and you are under age 19.

We also cover:

a. Ear molds and replacement ear molds 4 times per year if you are under age 8 and once per year if you are age 8 to 25

b. Initial batteries and one box of replacement batteries per year for each hearing aid if you are under age 26

The hearing aid must be prescribed, fitted and supplied by an audiologist or hearing aid specialist and referred by a licensed physician. We may cover a new hearing aid sooner if your existing hearing aid cannot be changed to meet your needs and you are under age 19.

Routine hearing exams are not covered in this section.

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

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

7.4.18 Home Healthcare and Skilled Nursing Care

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

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

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

There is an 8-hour maximum allowed in any one day (24 hour period) for the services of a registered or licensed practical nurse. All other types of home healthcare providers are limited to one visit per day. Benefits for physical, occupational, speech, or respiratory therapy will also be subject to the 60 visits per year as stated in the benefit for outpatient rehabilitation (see section 7.4.35).

You may receive skilled nursing care from a nurse who ordinarily resides in your home or who is related to you by blood or marriage if documentation is provided to us that the nurse would otherwise be gainfully employed as a nurse. However, the Plan will provide benefits for only one 8-hour shift by such a nurse in a 24-hour period.

Home healthcare and skilled nursing care require prior authorization. You should contact Moda Health Customer Service before receiving such care.

Home health visits have a calendar year maximum. Home health aides are not covered. If you are in hospice, your home healthcare, home care services and supplies are covered under sections 7.4.13 and 7.4.19.

7.4.19 Hospice Care

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

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

Hospice Home Care

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

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

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

Hospice Inpatient Care

Short term hospice inpatient services and supplies are covered.

Respite Care

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

Exclusions

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

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

7.4.20 Hospital Care

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

a. Hospital room
b. Intensive care unit
c. Isolation care to protect you or other patients from spreading illness
d. Facility charges for surgery performed in a hospital outpatient department
e. Other hospital services and supplies (including prescription medications dispensed while the member is hospitalized) when medically necessary for treatment and ordinarily

provided by a hospital. These include, but are not limited to, operating and recovery room, and traction equipment

f. Take-home prescription drugs **are limited to a 3-day supply** at the same benefit level as hospitalization. (Refer to section 7.6 for the retail and/or mail order prescription medication coverage)

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

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

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

7.4.21 Hospital Visits

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

7.4.22 Inborn Errors of Metabolism

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

7.4.23 Infertility Diagnosis

Diagnosis of infertility including office visits, lab tests, imaging services and outpatient procedures are covered up to a lifetime maximum of $10,000 for each member.

7.4.24 Infusion Therapy

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

a. Solutions, medications, and pharmaceutical additives
b. Pharmacy compounding and dispensing services
c. Durable medical equipment (DME) for the infusion therapy
d. Ancillary medical supplies
e. Nursing services
f. Collection, analysis and reporting of the results of laboratory testing services needed to monitor your response to therapy

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

7.4.25 Kidney Dialysis
Covered expenses include:
a. Treatment planning
b. Professional services for administration and supervision
c. Treatments, including therapist, facility and equipment charges

7.4.26 Massage Therapy
Massage therapy must be performed by a professional provider within their scope of license to be eligible for coverage.

7.4.27 Maxillofacial Prosthetic Services
Maxillofacial prosthetic services you need to restore and manage head and facial structures that cannot be replaced with living tissue are covered when you need these services to:
a. Control or eliminate infection or pain
b. Restore facial configuration or functions such as speech, swallowing or chewing

The problem must be because of:
a. Disease
b. Trauma
c. Birth and developmental deformities

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

7.4.28 Medication Administered by Provider, Treatment/Infusion Center or Home Infusion
A medication that must be given in a professional provider's office, treatment or infusion center or home infusion is usually covered at the same benefit level as supplies and appliances (see Section 3).

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

See section 7.4.24 for more information about infusion therapy. Self-administered medications are not covered under this benefit. See section 7.6 for pharmacy benefits.

7.4.29 Naturopathic Supplies
Services by a licensed naturopathic physician acting within the scope of their license are covered. Services must not be specifically excluded under the Plan.

Covered naturopathic treatment includes the following when prescribed and dispensed by your naturopathic physician:
a. Office supplies
b. Substances approved by the Board of Naturopathic Examiners

Lab and diagnostic x-rays or physical therapy ordered by your naturopathic physician are not covered under this benefit. They are paid under the Plan's standard in-network benefit for the type of service. Office visits by naturopathic physicians are specialist office visits.

7.4.30 Nonprescription Enteral Formula for Home Use

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

7.4.31 Nutritional Therapy

Nutritional therapy is covered when medically necessary. It must be authorized after the first 5 visits. Preventive nutritional therapy required under the Affordable Care Act is covered under the preventive care benefit. Also see diabetes services (section 7.4.10) and inborn errors of metabolism (section 7.4.22).

7.4.32 Office or Home Visits

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

In-network copay is waived for PCP or specialist visits related to management of these chronic conditions: asthma, heart disease, high blood pressure, diabetes, high cholesterol and behavioral health.

7.4.33 Podiatry Services

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

7.4.34 Pre-admission Testing

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

7.4.35 Rehabilitation & Habilitation

Covered rehabilitative services are:

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

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

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

Outpatient rehabilitative services have an annual limit. The limit does not apply to medically necessary cardiac or pulmonary rehabilitation or services for behavioral health conditions. A session is one visit. Only one session of each type of outpatient physical, occupational or speech therapy is covered in one day. Medical necessity review is required after 30 sessions.

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

Habilitative services are used to form skills that you never developed due to a medical condition. Only outpatient habilitative physical, occupational or speech therapy is covered. It must be medically necessary to treat a mental health condition.

7.4.36 Skilled Nursing Facility Care

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

A limited number of days are covered. Care beyond that may be authorized by us when the attending physician reports that additional skilled nursing care is necessary for treatment of that illness or injury. Covered expenses are limited to the daily service rate for a semi-private hospital room.

Exclusions

These skilled nursing facility charges are not covered:

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

7.4.37 Spinal Manipulation

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

7.4.38 Surgery

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

The surgery cost sharing also applies to these services:

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

Certain surgical procedures are covered only when performed as outpatient surgery. Ask your professional provider if this applies to a surgery you are planning, or ask Customer Service. Outpatient surgery does not require an inpatient admission or a stay of 24 hours or more. Outpatient surgery requires prior authorization (see Section 6).

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

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

Surgery for breast enhancement, making breasts match, and replacing breast implants to change the shape or size of your breasts is not covered, except to treat gender dysphoria (see section 7.4.14) or after a mastectomy.

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

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

7.4.39 Temporomandibular Joint Syndrome (TMJ)
TMJ treatment may be covered when:
a. You have pain
b. You cannot chew properly
c. For severe acute trauma

All TMJ related services, including but not limited to diagnosis, surgery and splints to treat TMJ must be prior authorized. There is a lifetime maximum on TMJ benefits. Benefits for TMJ surgery are paid at the regular Plan benefit for surgery. Benefits for splints and adjustments related to TMJ treatment are limited to a $1,500 lifetime maximum. Treatment of dental diseases or injuries is excluded. If you are also enrolled in the Delta Dental Plan provided by the Group, you have limited coverage for nightguards under the Delta Dental Plan.

7.4.40 Therapeutic Injections
Administrative services for therapeutic injections, such as allergy shots, are covered when you get them in a professional provider's office. When you can get similar results with self-administered medications at home, the administrative services for therapeutic injections by your provider are not covered. Vitamin and mineral injections are not covered unless they are medically necessary to treat a specific medical condition. More information is in section 7.4.28.

7.4.41 Therapeutic Radiology

Covered expenses include:

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

7.4.42 Transplants

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

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

We cover medically necessary transplants that follow standard medical practice and are not experimental or investigational. Your doctor should get prior authorization as soon as possible after you know you may be a possible transplant candidate. This section's requirements do not apply to corneal transplants and collecting and/or transfusing blood or blood products (see section 7.4.38).

Benefits for transplants are limited as follows:

a. Transplant procedures must be done at a Center of Excellence. If a Center of Excellence cannot provide the necessary type of transplant, we will prior authorize services at another transplant facility.
b. Donor costs are covered as follows:
    i. If you are the recipient or self-donor, donor costs related to a covered transplant are covered. If the donor is also enrolled in the Plan, expenses resulting from complications and unforeseen effects of the donation are covered.
    ii. If you are the donor and the recipient is not enrolled in the Plan, we will not pay any benefits toward donor costs.
    iii. If the donor is not enrolled in the Plan, expenses that result from complications and unforeseen effects of the donation are not covered.
c. Professional provider transplant services are paid according to the benefits for professional providers.
d. Immunosuppressive drugs you get during a hospital stay are paid as a medical supply. Outpatient oral and self-injectable prescription medications for transplant related services are paid under the Pharmacy Prescription benefit (section 7.6).
e. We will not pay for chemotherapy with autologous or homogenic/allogenic bone marrow transplant for treatment of any type of cancer not approved for coverage.

Please Note:

All transplant related procedures and services, including the pre-transplant evaluation, must be prior authorized for the type of transplant and be medically necessary and appropriate according to criteria established by Moda Health and developed using nationally recognized transplant program criteria.

Exclusions

In addition to the exclusions listed in Section 8, 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.

Definitions
A Center of Excellence is a facility and/or team of professionals that we have agreements with to provide transplant services. Centers of Excellence follow best practices and have exceptional skills and expertise in managing patients with a specific condition.

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

7.4.43 Virtual Care Visits (Telemedicine)

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

A virtual care visit is covered if:

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

In-network copay is waived for visits related to management of these chronic conditions: asthma, heart disease, high blood pressure, diabetes, high cholesterol and behavioral health.

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

7.5 MATERNITY CARE

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

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

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

7.5.1 Abortion

Abortions and miscarriage services, including procedures, office visits and related labs, are covered at no cost sharing when performed by an in-network provider.

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

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

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

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

Services include:

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

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

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

7.5.7 Hospital Benefits
Covered hospital maternity care expenses are:

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

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

7.6 PHARMACY PRESCRIPTION BENEFIT

7.6.1 WellDyneRx Pharmacy Program

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

Prescription medication benefits provide coverage for eligible outpatient prescription medication charges incurred at a retail pharmacy, including any participating WellDyneRx pharmacy, or through an exclusive mail order pharmacy. The medical deductible does not apply to prescription medications. WellDyneRx maintains a Preferred Drug List (PDL) which designates the coverage tier for each medication. The tiers are: Value, Tier 1 for Select, Tier 2 for Preferred, and Tier 3 for Non-Formulary.

The prescription medication plan has a $2,000 Per Person /$6,000 per family plan year out-of-pocket maximum that applies to Value, Select, Preferred, and non-formulary medications. The amount you pay toward the covered expense for these medications will apply toward the out-of-pocket maximum. This out-of-pocket maximum is calculated separately from any other out-of-pocket limit that may apply to the medical plan. Once the out-of-pocket maximum is met, covered medications will be reimbursed at 100%.

7.6.2 Covered Medication Supply

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

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

Certain prescription medications and/or quantities of prescription medications may need to be prior authorized (see Section 6).

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

7.6.3 Retail Pharmacy benefit (limited to 30 day supply)

The coinsurance for a 30 day supply from an in-network pharmacy is:

Rx Tier	Medication Category	Member Coinsurance
Value	Value	20% up to $4 maximum
Tier 1	Select	20% to $50 maximum
Tier 2	Preferred	20% to $50 maximum
Tier 3	Non-Formulary	50%

When using an out-of-network pharmacy, you are responsible for any amount above the MPA.

7.6.4 Mail Order Pharmacy benefit (limited to 90 day supply)

You have the option of obtaining covered medications through an exclusive mail order pharmacy. The coinsurance for a 90 day supply of medication from the exclusive mail order pharmacy is:

Rx Tier	Medication Category	Member Coinsurance
Value	Value	20% up to $8 maximum
Tier 1	Select	20% to $30 maximum
Tier 2	Preferred	20% to $125 maximum
Tier 3	Non-Formulary	50%

A mail order pharmacy form can be obtained from the Group or by contacting WellDyneRx Customer Service.

7.6.5 Specialty Services & Pharmacy benefit (limited to 30 day supply)

The pharmacist and other professional providers will tell you if a prescription requires delivery by an exclusive specialty pharmacy. Specialty medications are often used to treat complex chronic health conditions. Information about the clinical services and a list of covered specialty medications is available by contacting WellDyneRx Customer Service. **If you do not purchase specialty medications at the exclusive specialty pharmacy, the expense will not be covered.**

Rx Tier	Medication Category	Member Coinsurance
Tier 1	Select	20% to $50 maximum
Tier 2	Preferred	20% to $50 maximum
Tier 3	Non-Formulary	50%

Some specialty prescriptions may have shorter day supply coverage limits. More information is available by contacting WellDyneRx Customer Service.

Although Specialty medications are shipped through the mail, they are not eligible for the mail-order program due to the complexity of the medications and the conditions that are being treated.

7.6.6 WellDyneRx Intercept Specialty Pharmacy Program

The WellDyneRx Pharmacy Benefit Management Intercept specialty medication program facilitates the use of certain pharmaceutical manufacturer coupons to reduce cost to the plan and participating members. WellDyneRx informs you of the program when an eligible medication is prescribed. You enroll for the coupons directly with the manufacturer, typically over the phone. WellDyneRx is available to assist with this process.

Under this program, plan copay/coinsurance for eligible specialty medications will be 40% of the cost of Intercept eligible medications. If you choose not to enroll, the 40% copay/coinsurance will apply.

You may only use coupons for eligible specialty medications as part of the Intercept program through the Plan unless prior consent is obtained from the Group.

First and subsequent fills of specialty medications are to be filled through US Specialty Care Pharmacy, allowing for reasonable, limited exceptions by the Group and/or WellDyneRx.

Inclusion of any given medication in the Intercept program is subject to change at any time without notice, at which time the standard plan copay/coinsurance would apply.

7.6.7 Utilization Management

7.6.7.1 Prior Authorization

Certain prescription medications and/or quantities of prescription medications may require prior authorization. A complete list of medications that require prior authorization is available by contacting WellDyneRx Customer Service.

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

7.6.8 Limitations

a. In addition to those medications included in the current prior authorization list, prior authorization is required for
    i. Retail prescriptions with a net cost over $1,000 for a 30-day supply
    ii. Mail-order prescriptions with a net cost over $3,000
    iii. Specialty prescriptions with a net cost over $3,000
    iv. Compounded medications with a net cost over $150 for a 30-day supply
b. New FDA approved medications will be reviewed. We may have coverage requirements or limits. You or your prescriber can ask for a medical necessity evaluation if we do not cover a newly approved medication during the review period.
c. Medications with dosing intervals greater than the Plan's maximum day supply will have an increased copayment to match the day supply.
d. Medications you buy outside the United States and its territories are only covered in emergency and urgent care situations.
e. You may ask to have your medication refilled early if you are going to travel outside of the United States. When we allow an early refill, it is limited to once every 6 months. You

cannot get an early refill to extend your medication supply beyond the end of the plan year.

f. If you need an emergency refill of insulin or diabetic supplies, we will cover it no more than 3 times per year. We will only cover the smallest available package or a 30-day supply, whichever is less.

7.6.9 Exclusions

The following services, procedures and conditions are not covered by the prescription medication plan under the Pharmacy Prescription Benefit, even if otherwise medically necessary or if recommended, referred, or provided by a professional provider, pharmacist or pharmacy. In addition, any direct complication or consequence that arises from these exclusions will not be covered. See Section 8 for additional exclusions that may apply.

a. **Devices.** Including, but not limited to therapeutic devices and appliances. Some devices could be covered under the medical plan
b. **Foreign Medication Claims.** Medications you buy from non-U.S. mail order or online pharmacies or U.S. mail or online pharmacies acting as agents of non-U.S. pharmacies
c. **Hair Growth Medications.**
d. **Immunization Agents for Travel.** Except as required under the Affordable Care Act
e. **Institutional Medications.** To be taken or administered while you are a patient in a hospital, rest home, skilled nursing facility, extended care facility, nursing home or similar institution
f. **Medication Administration.** A charge to administer or inject a medication, except for immunizations or contraceptives at in-network retail pharmacies. Some administration charges could be covered under the medical plan
g. **Medications Covered Under Another Benefit.** Such as medications covered under home health, medical, etc.
h. **Medications Not Approved by FDA.** Products not recognized or designated as FDA approved medications. This includes medications that are found to be less than effective by the FDA's Drug Efficacy Study Implementation (DESI) classifications.
i. **Non-Covered Condition.** A medication prescribed for reasons other than to treat a covered medical condition
j. **Nutritional Supplements and Medical Foods.** Unless determined to be medically necessary
k. **Off-label Use.** Medications prescribed for or used for non-FDA approved indications, unless Oregon's Health Evidence Review Commission or Pharmacy Therapeutics and Review Committee has approved it
l. **Over the Counter (OTC) Medications** and certain prescription medications that have an OTC option, except for contraceptives and emergency contraceptives, condoms, spermicide or those treating tobacco dependence
m. **Pharmacies excluded from the network**. Medications from pharmacies that have been excluded from the network for non-compliance with fraud, waste and abuse laws
n. **Repackaged Medications.**
o. **Replacement Medications and/or Supplies.**
p. **Untimely Dispensing.** Medications that are dispensed more than one year after the order of a professional provider
q. **Vitamins and Minerals.** Except as required by law
r. **Weight Loss Medications.**

7.6.10 Appeal Process For Prescription Medication Benefits

If you have medical reasons that prevent use of a Tier 1 or Tier 2 medication, there is a process available to request an exception to Tier 3 status.

You may request an override to the formulary, which would allow a medication that usually has a Tier 3 coinsurance to be dispensed with a lower coinsurance and/or have the coinsurance apply to the plan year prescription medication out-of-pocket maximum. The formal written request should be submitted to:

ATTN: Rx Prior Auth – Multnomah County Tiering Request
WellDyneRx
P.O. Box 3129
Englewood, CO 80155
Fax 888-830-3608

The request should be written by your professional provider and include explanation of the documented medical reactions caused by use of the medication on the formulary, or lack of therapeutic response to formulary medications. If use of a generic medication caused you to experience an adverse medical reaction, or experience a lack of therapeutic response, the physician must confirm the completion and submission of the MEDWATCH form to the U.S. Food and Drug Administration. Additional information regarding MEDWATCH submissions can be found at: http://www.fda.gov/Safety/Medwatch/HowToReport/ucm085568.htm.

These requests are reviewed by medical professionals and a decision will be made whether to approve or decline the request. You will be advised in writing of the decision.

7.6.11 Definitions

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

Brand Substitution. Is a policy that applies to brand medications filled at the pharmacy when a generic option is available. Both generic and brand medications are covered. If you request, or the treating professional provider prescribes, a brand medication when a generic equivalent is available, you will be responsible for the brand cost sharing plus the difference in cost between the generic and brand medication. Because there are pharmaceutical alternatives and/or equivalents available, the coinsurance for these medications does not apply towards the out-of-pocket maximum.

Formulary is a list of all prescription medications and how they are covered under the pharmacy prescription benefit.

Generic Medications are medications that have been found by the Food and Drug Administration (FDA) to be therapeutically equivalent to the brand option and will often save you money. Generic medications must have the same active ingredients as the brand version and be identical in strength, dosage form and the way you take them. Therapeutic equivalence of generic medications is determined by the FDA approval process, the professional provider at the point of prescribing, and the pharmacist at the point of dispensing according to state pharmacy laws.

In-Network Pharmacy refers to a pharmacy that has contracted with WellDyneRx to provide prescription medication benefits to members.

Non-Formulary Tier 3 Medications are medications, including specialty Non-Formulary medications, have been reviewed by WellDyneRx and do not have significant therapeutic advantage over their preferred alternatives(s). These products generally have safe and effective alternative options available under Tier 1 or Tier 2. Non-Formulary medications apply towards the out of pocket maximum.

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

Preferred Tier 2 Medications. Medications, including specialty preferred medications, have been reviewed by WellDyneRx and found to be clinically effective at a favorable cost when compared to other medications in the same therapeutic class and/or category. Generic medications that have been identified as having no more favorable outcomes, from a clinical perspective, than other more cost effective generic medications may be included in this tier.

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

Select Tier 1 Medications are generic medications that represent the most cost effective option within their therapeutic category. This category may include certain brand medications that are both clinically favorable and cost effective .

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

Value Tier Medications include commonly prescribed medications used to treat chronic medical conditions. They are considered safe, effective and cost-effective compared to other medication options. A list of value medications is available by contacting WellDyneRx.

7.7 ROUTINE VISION CARE BENEFIT

The Plan provides you with coverage for the following vision care services through VSP. See section 7.4.10 under the medical benefit for coverage of an annual dilated eye exam for management of diabetes.

7.7.1 Procedure for Using the Vision Care Plan

This includes:

a. To receive vision plan benefits from an in-network doctor, contact VSP at www.vsp.com or 1-800-877-7195 or contact an in-network doctor. A list of names, addresses, and phone numbers of in-network doctors within your geographic location can be obtained from the Group or VSP. If this list does not cover the geographic area necessary to seek services, you may call or write to the nearest VSP office to obtain one that does.

b. If you are eligible for vision plan benefits, VSP will provide benefit authorization directly to the in-network doctor. When contacting an in-network doctor directly, you must

identify yourself as a VSP member so the doctor will obtain benefit authorization from VSP.

c. When such benefit authorization is provided by VSP, and services are performed prior to the expiration date of the benefit authorization, this will constitute a claim against the vision care plan in spite of your termination of coverage or the termination of the vision care plan. Should you receive services from an in-network doctor without such benefit authorization or obtain services from a provider who is not an in-network doctor, you are responsible for payment in full to the provider.

d. You pay only the copayment (if any) to an in-network doctor for services covered by the vision care plan. VSP will pay the in-network doctor directly according to its agreement with the doctor.

   Note: If you are eligible for and obtain plan benefits from an out-of-network provider you should pay the provider the full fee. Then you will be reimbursed by VSP in accordance with the out-of-network provider reimbursement schedule shown in section 7.7.4, less any applicable copayments.

e. Medically necessary emergency vision care is provided through the medical plan.

f. In the event of termination of an in-network doctor's membership in VSP, VSP will remain liable to the in-network doctor for services rendered to you at the time of termination and permit the in-network doctor to continue to provide you with vision plan benefits until the services are completed or until VSP makes reasonable and appropriate arrangements for the provision of such services by another authorized doctor.

7.7.2 Benefit Authorization Process

VSP authorizes vision plan benefits according to the latest eligibility information furnished to VSP by the Group and the level of coverage (i.e. service frequencies, covered materials, reimbursement amounts, limitations, and exclusions) purchased for you by the Group under this vision care plan. When you request vision services, your prior utilization of vision plan benefits will be reviewed by VSP to determine if you are eligible for new services based upon the Plan's level of coverage. Please refer to sections 7.7.3 and 7.7.4 for a summary of the level of coverage provided by the Group.

7.7.3 Benefits and Coverages

Through its in-network doctors, VSP provides vision plan benefits to you, subject to the limitations, exclusions, and copayment(s) described in the following sections. To obtain vision plan benefits from an in-network doctor, you should contact the in-network doctor of your choice, identify yourself as a VSP member, and schedule an appointment. If you are eligible for vision plan benefits, VSP will provide benefit authorization directly to the in-network doctor prior to an appointment.

IMPORTANT: Refer to section 7.7.4 to determine specific Plan Benefits.

a. Eye Examination: A complete initial vision analysis which includes an appropriate examination of visual functions, including the prescription of corrective eyewear where indicated.

b. Lenses: The in-network doctor will order the proper lenses necessary for your visual welfare. The doctor shall verify the accuracy of the finished lenses.
c. Frames: The in-network doctor will assist in the selection of frames, properly fit and adjust the frames, and provide subsequent adjustments to frames to maintain comfort and efficiency.
d. Contact lenses: Unless otherwise indicated in section 7.7.4, contact lenses are available under this vision care plan in lieu of all other lens and frame benefits described herein for the current eligibility period.

   Necessary contact lenses, together with professional services, will be provided as indicated in section 7.7.4.

   When Elective contact lenses are obtained from an in-network doctor, VSP will provide an allowance toward the cost of professional fees and materials as shown in section 7.7.4. The vision care plan covers the contact lens fitting and evaluation exam in full when provided by an in-network doctor. Contact lens materials are provided at the in-network doctor's usual and customary charges.

e. If you elect to receive vision care services from an in-network doctor, vision plan benefits are provided subject only to payment of any applicable copayment. When obtaining vision plan Benefits from an out-of-network provider, you should pay the out-of-network provider the full fee. VSP will reimburse you in accordance with the reimbursement schedule shown in section 7.7.4, less any applicable copayment. THERE IS NO ASSURANCE THAT THE SCHEDULE WILL BE SUFFICIENT TO PAY FOR THE EXAMINATION OR THE MATERIALS. Availability of services under the out-of-network provider reimbursement schedule is subject to the same time limits and copayments as those described for in-network doctor services. Services obtained from an out-of-network provider are in lieu of obtaining services from an in-network doctor and count toward plan benefit frequencies.
f. Low Vision Services and Materials: The low vision benefit provides special aid if you have acuity or visual field loss that cannot be corrected with regular lenses. If you fall within this category, you will be entitled to professional services as well as ophthalmic materials, including but not limited to, supplemental testing, evaluations, visual training, low vision prescription services, plus optical and non-optical aids, subject to the frequency and benefit limitations as outlined in section 7.7.4. Consult an in-network doctor for details.

   Low vision benefits provided by VSP providers, including:

Types of services	What the Plan pays (In-Network Providers)	What the plan Pays (Out-of-Network Providers)
Supplemental Testing (includes evaluation, diagnosis and prescription of vision aids where indicated)	Covered in full	Up to $125
Supplemental Aids	75% of cost	75% of cost
*Maximum allowable for all low vision benefits of $1,000 every 2 years.		

Low vision benefits provided by Affiliated Providers including:

Types of services	What the Plan pays
Supplemental Testing (includes evaluation, diagnosis and prescription of vision aids where indicated)	Up to $125
Supplemental Aids	75% of affiliate provider's fee up to $1,000
* Maximum benefit for all low vision services and materials is $1,000 every 2 years and a maximum of 2 supplemental tests within a 2-year period. Low vision services are vision plan benefits when specific benefit criteria are satisfied and when prescribed by the member's doctor.	

7.7.4 Copayment

The benefits described herein are available subject only to the payment of any applicable Copayment(s) as described below. ANY ADDITIONAL CARE, SERVICE AND/OR MATERIALS NOT COVERED BY THIS PLAN MAY BE ARRANGED BETWEEN A MEMBER AND THE DOCTOR.

Benefit (Adults and Children Age 19 and older)	**Description**	**Copay**	**Frequency for Adults and Children over 19**
Well vision exam	• Covered in full at VSP doctor or participating retail provider • Not all independent doctors in Costco are participating retail providers	$0	Every calendar year
1 Frame	• $200 allowance • 20% savings on the amount over the allowance at VSP doctors and participating retail chains except Costco • $110 Costco frame allowance	$0	Every other calendar year
1 pair of Lenses	Single vision, lined bifocal and lined trifocal lenses	$0	Every calendar year
Lens Enhancement	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 20-25% on other lens enhancements at VSP doctors and participating retail chains except Costco	$55 $95-$105 $150-$175	Every calendar year
Contacts (instead of glasses)	• $200 allowance • Contact lens exam (fitting and evaluation)	$0	Every calendar year
Diabetic Eyecare Plus Program	Services related to diabetic eye disease, glaucoma and age-related macular degeneration (AMD). Retinal screening for eligible members with diabetes. Available at VSP doctors only and pays secondary to other medical coverage	$20	As needed

Extra Savings	• 20% savings on additional glasses and sunglasses from any VSP provider within 12 months of the last well vision exam • No more than a $39 copay on routine retinal screening • For laser vision correction, average 15% off the regular price or 5% off the promotional price	N/A	As needed
Maximum Allowances with Out-of-Network Providers	• Exam – up to $70 • Frame – up to $96 • Single vision lenses – up to $30 • Bifocal lenses - up to $50 • Trifocal lenses – up to $65 • Progressive lenses – up to $50 • Contacts – up to $195	$0	Every calendar year except frame is every other calendar year

Benefit (Children under age 19)	**Description**	**Copay**	**Frequency for children under 19**
Well vision exam	• Covered in full at VSP doctor or participating retail provider • Not all independent doctors in Costco are participating retail providers	$0	Every calendar year
1 Frame	• Up to $200 allowance • 20% savings on the amount over the allowance at VSP doctors and participating retail chains except Costco Optical • $110 Costco frame allowance	$0	Every calendar year
1 pair of Lenses	Single vision, lined bifocal and lined trifocal lenses	$0	Every calendar year
Lens Enhancement	• UV coating • Scratch-resistant coating • Polycarbonate lenses • Average savings of 20-25% on other lens enhancements at VSP doctors and participating retail chains except Costco	$0	Every calendar year
Contacts (instead of glasses)	• Up to $200 allowance • Contact lens exam (fitting and evaluation)	$0	Every calendar year
Diabetic Eyecare Plus Program	Services related to diabetic eye disease, glaucoma and age-related macular degeneration (AMD). Retinal screening for eligible members with diabetes. Available at VSP doctors only and pays secondary to other medical coverage	$20	As needed

Extra Savings	• 20% savings on additional glasses and sunglasses from any VSP provider within 12 months of the last well vision exam • No more than a $39 copay on routine retinal screening • For laser vision correction, average 15% off the regular price or 5% off the promotional price	N/A	As needed
Maximum Allowances with Out-of-Network Providers	• Exam – up to $70 • Frame – up to $96 • Single vision lenses – up to $30 • Bifocal lenses - up to $50 • Trifocal lenses – up to $65 • Progressive lenses – up to $50 • Contacts – up to $195	$0	Every calendar year

7.7.5 Exclusions and Limitations of Benefits

Some brands of spectacle frames may be unavailable for purchase as vision plan benefits, or may be subject to additional limitations. You may obtain details regarding frame brand availability from your in-network doctor or by calling VSP's Customer Care Division at (800) 877-7195.

This vision care plan is designed to cover visual needs rather than cosmetic materials. If you select any of the following options, the vision care plan will pay the basic cost of the allowed lenses or frames, and you will be responsible for the option's extra cost, unless it is defined as a vision plan benefit in section 7.7.4.

- Optional cosmetic processes.
- Anti-reflective coating.
- Color coating.
- Mirror coating.
- Blended lenses.
- Cosmetic lenses.
- Laminated lenses.
- Oversize lenses.
- Photochromic lenses, tinted lenses except Pink #1 and Pink #2.
- Progressive multifocal lenses.
- Certain limitations on low vision care.

There is no benefit for professional services or materials connected with:

- Orthoptics or vision training and any associated supplemental testing; plano lenses (less than ±.50 diopter power); or two pair of glasses in lieu of bifocals.
- Replacement of lenses and frames furnished under this plan which are lost or broken except at the normal intervals when services are otherwise available.
- Medical or surgical treatment of the eyes.
- Corrective vision treatment of an Experimental Nature.
- Costs for services and/or materials above Plan Benefit allowances indicated in section 7.12.5.
- Services/materials not indicated as covered Plan Benefits in sections 7.7.3 and 7.7.4.

7.7.6 Liability in Event of Nonpayment

In the event VSP fails to pay the provider, you shall not be liable to the provider for any sums owed by the vision care plan other than those not covered by the vision care plan.

7.7.7 Complaints and Grievances

If you ever have a question or problem, the first step is to call VSP's Customer Service Department. The Customer Service Department will make every effort to answer your question and/or resolve the matter informally. If a matter is not initially resolved to your satisfaction, you may communicate a complaint or grievance to VSP orally or in writing by using the complaint form that may be obtained upon request from the Customer Service Department. Complaints and grievances include disagreements regarding access to care, or the quality of care, treatment or service. You also have the right to submit written comments or supporting documentation concerning a complaint or grievance to assist in VSP's review. VSP will resolve the complaint or grievance within thirty (30) days after receipt, unless special circumstances require an extension of time. In that case, resolution shall be achieved as soon as possible, but no later than one hundred twenty (120) days after VSP's receipt of the complaint or grievance. If VSP determines that resolution cannot be achieved within thirty (30) days, a letter will be sent to you to indicate VSP's expected resolution date. Upon final resolution, you will be notified of the outcome in writing.

7.7.8 Claim Payments and Denials

a. Initial Determination: VSP will pay or deny claims within thirty (30) calendar days of the receipt of the claim from you or your authorized representative. In the event that a claim cannot be resolved within the time indicated VSP may, if necessary, extend the time for decision by no more than fifteen (15) calendar days.

b. Request for Appeals: If your claim for benefits is denied by VSP in whole or in part, VSP will notify you in writing of the reason or reasons for the denial. Within one hundred eighty (180) days after receipt of such notice of denial of a claim, you may make a verbal or written request to VSP for a full review of such denial. The request should contain sufficient information to identify the member for whom a claim for benefits was denied, including the name of the subscriber, member identification number of the subscriber, the member's name and date of birth, the name of the provider of services and the claim number. You may state the reasons you believe that the claim denial was in error. You may also provide any pertinent documents to be reviewed. VSP will review the claim and give you the opportunity to review pertinent documents, submit any statements, documents, or written arguments in support of the claim, and appear personally to present materials or arguments. You or your authorized representative should submit all requests for appeals to:

    VSP
    Member Appeals
    3333 Quality Drive
    Rancho Cordova, CA 95670
    (800) 877-7195

VSP's determination, including specific reasons for the decision, shall be provided and communicated to you within thirty (30) calendar days after receipt of a request for appeal from you or your authorized representative.

If you disagree with VSP's determination, you may request a second level appeal within sixty (60) calendar days from the date of the determination. VSP shall resolve any second level appeal within thirty (30) calendar days.

7.7.9 Definitions

Benefit Authorization. Authorization issued by VSP identifying the individual named as a member, and identifying those vision plan benefits to which a member is entitled.

Copayments. Any amounts required to be paid by or on behalf of a member for vision plan benefits which are not fully covered.

Experimental Nature. Procedure or lens that is not used universally or accepted by the vision care profession, as determined by VSP.

In-Network Doctor. An optometrist or ophthalmologist who is licensed and otherwise qualified to practice vision care and/or provide vision care materials and has contracted with VSP to provide vision care services and/or vision care materials on the member's behalf.

Member. Employees or dependents who have been verified by VSP as eligible for vision plan benefits through VSP.

Out-of-Network Provider. Any optometrist, optician, ophthalmologist, or other licensed and qualified vision care provider who has not contracted with VSP to provide vision care services and/or vision care materials to members.

Subscriber. An employee of the Group who meets the criteria for eligibility specified in Section 10.

Vision Plan Benefits. The vision care services and vision care materials which a member is entitled to receive by virtue of coverage under the Group's vision care plan, as defined in sections 7.7.3 and 7.7.4.

SECTION 8. GENERAL EXCLUSIONS

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

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

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

Charges Over the Maximum Plan Allowance
Except when required under the Plan's coordination of benefits rules (see section 9.4.1)

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

Cosmetic Procedures
Any procedure or medication with the main purpose of changing or maintaining your appearance and that will not result in significant improvement in body function. Examples include hormone treatment, rhinoplasty, breast enhancement, liposuction and hair removal. Reconstructive or gender confirming surgery is covered if medically necessary and not specifically excluded (see section 7.4.38).

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

Dental Examinations and Treatment; Orthodontia
Except services described in sections 7.4.9 and 7.4.27, or if medically necessary to restore function due to craniofacial irregularity

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

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

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

Faith Healing

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

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

Homeopathic Treatment and Supplies

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

Infertility
All services and supplies for treatment of infertility.

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

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

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

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

Obesity or Weight Reduction
Even if you are morbidly obese. Services and supplies including:

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

The Plan covers services and supplies that are necessary to treat established medical conditions that may be caused by or made worse by obesity. Services and supplies that do so by treating the obesity directly are not covered, except as required under the Affordable Care Act.

Orthopedic Shoes
Except as described in section 7.4.13

Orthognathic Surgery
Including associated services and supplies

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

Physical Exercise Programs
Programs, videos and exercise equipment

Private Nursing Services

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

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

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

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

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

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

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

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

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

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

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

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

Services Provided by Volunteer Workers

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

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

Taxes, Fees and Interest
Except as required by law

Telehealth
Except telemedicine as specifically described in section 7.4.43

Telephones and Televisions in a Hospital or Skilled Nursing Facility

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

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

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

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

Treatment After Coverage Ends
The only exception is covered hearing aids ordered before your coverage ends and you get them no more than 90 days after the end date.

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

Treatment for Hair Loss Including Wigs, Toupees, Hair Transplants
Services and supplies for treatment of hair loss, including but not limited to toupees, hair transplants and prescription medications, are not covered even if the hair loss is due to a condition that is otherwise covered by the Plan. Wigs, except when purchased after chemotherapy or radiation therapy, are not covered.

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

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

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

Please Note:
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
Please see information on vision on section 7.7.

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

Vitamins and Minerals
Except as required by law. Otherwise, not covered unless medically necessary to treat 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.

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

SECTION 9. CLAIMS ADMINISTRATION & PAYMENT

9.1 SUBMISSION & PAYMENT OF CLAIMS

What to know about sending us a claim:

a. Moda Health or WellDyneRx must receive your claim no more than 12 months after the date of service
b. We do not always pay claims in the same order you received the services. This may affect how your cost sharing is applied to claims. For example, a deductible may not be applied to the first date you were seen in a benefit year if we pay a later date of service first
c. We will not pay any claims we do not receive on time. The only exceptions are Medicaid claims or absence of legal capacity. Claims from Medicaid must be sent to Moda Health or WellDyneRx no more than 3 years after the date of service. VSP Medicaid claims must be submitted within 1 year from date of service
d. We may pay benefits to you, to the provider, or both of you

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

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

9.1.1 How to Send Us Claims

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

Include all of the following information:

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

Some claims will require additional information:

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

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

9.1.2 Prescription Medication Claims

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

If you fill a prescription at an out-of-network pharmacy that does not access our claims payment system, or buy an OTC contraceptive, you will need to fill out and send in the prescription medication claim form. This form is available by contacting WellDyneRx.

Submit the claim to: WellDyneRx
P.O. Box 3129
Englewood, CO 80155

9.1.3 Routine Vision Claims

To obtain Plan Benefits from an in-network doctor, you should contact the in-network doctor of your choice, identify yourself as a VSP member, and schedule an appointment. If you are eligible for Plan Benefits, VSP will provide Benefit Authorization directly to the in-network doctor prior to an appointment.

When using an out-of-network provider, you should pay the provider the full fee. You will be reimbursed by VSP in accordance with the out-of-network provider reimbursement schedule shown on the schedule of allowances less any applicable copayments. You can submit out-of-network claims online as a registered member on vsp.com or by obtaining the form on vsp.com. All claims for services received from out-of-network providers shall be submitted by you to VSP within three hundred sixty-five (365) days of the date of service. VSP reserves the right to reject such claims which are filed more than three hundred sixty-five (365) days after the date of service. Failure to submit a claim within three hundred sixty-five (365) days, however, shall not invalidate or reduce the claim if it was not reasonably possible to submit the claim within such time period, provided the claim was submitted as soon as was reasonably possible and in no event, except in absence of legal capacity, later than one year from the required date.

Submit the claim to: VSP
P.O. Box 385018
Birmingham, AL 35238-5018

9.1.4 Explanation of Benefits (EOB)

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

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

9.1.5 Claim Inquiries

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

9.1.6 Time Frames for Processing Claims

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

a. If the claim is denied, we will send an EOB explaining the denial
b. If we need more time for reasons beyond our control, we will send you a notice of delay explaining those reasons. We will finish processing the claim no more than 45 days after we receive it

c. If we need more information, the notice of delay will describe the information we need. Whoever is responsible for providing the additional information will have 45 days to send it to us. We will finish processing the claim no more than 15 days after we get the additional information

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

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

9.2 COMPLAINTS, APPEALS & EXTERNAL REVIEW

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

9.2.1 Time Limit for Submitting Appeals

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

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

9.2.2 The Review Process

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

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

Note:
The timelines in the sections below do not apply when you do not reasonably cooperate; or circumstances beyond the control of either party (Moda Health/WellDyneRx or you) 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.

How First and Second Level Appeals Work

a. Submit your appeal in writing, on time, to Moda Health for medical benefits, WellDyneRx for prescription medication benefits and VSP for vision care benefits. Please see section 7.7.7 for VSP appeal process. If you need help, ask Customer Service
b. Someone who was not involved in the original decision will investigate your appeal

c. Moda Health or WellDyneRx will send the decision to you within 15 days of a pre-service appeal or 30 days of a post-service appeal

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

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

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

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

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

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

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

Only certain types of denials are eligible for external review. The IRO screens requests, and will review appeals that relate to
a. An adverse determination based on a utilization review decision
b. Whether surprise billing protections apply to an adverse benefit determination

c. Whether the treatment is an active course of treatment for purposes of continuity of care (see section 9.3)
d. Recission of coverage (section 10.8.6)
e. Cases in which Moda Health or WellDyneRx have not met the internal timeline for review or the federal requirements for providing related information and notices

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

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

9.2.4 Complaints

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

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

Moda Health or WellDyneRx will finish reviewing your complaint within 30 days. If they need more time, they will send you a letter letting you know about the delay. They will have 15 more days to make a decision. Please see section 7.7.7 for VSP complaints and grievance process.

9.2.5 Definitions

Please see section 7.7.7 for VSP appeal process. For purposes of section 9.2, the following definitions apply:

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

a. Rescission of coverage (section 10.8.6)
b. Eligibility to participate in the Plan
c. Network exclusion, annual benefit limit or other limitation on otherwise covered services
d. Utilization review (described below)
e. Limitations or exclusions described in Section 7 or Section 8, including a decision that an item or service is experimental or investigational or not medically necessary
f. Continuity of care (section 9.3) is denied because the course of treatment is not considered active

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

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

Complaint is an expression of dissatisfaction about a specific problem you have had or about a decision by Moda Health, WellDyneRx or someone acting for them 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 appeal is a pre-service appeal that needs a faster review because using the regular time period to review could

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

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

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

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

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

9.2.6 Additional Member Rights

You may contact the Multnomah County Employee Benefits Office for questions about your appeal rights or for assistance:

Multnomah County Employee Benefits Office
501 SE Hawthorne, Suite 320
Portland, OR 97214
Telephone: 503-988-3477
FAX: 503-988-6257
Email: employee.benefits@multco.us

9.3 CONTINUITY OF CARE

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

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

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

In addition:

a. Your provider must reasonably believe you have special circumstances that cause you harm if you were to discontinue treatment with them

b. Your provider must agree to follow the requirements of their most recent medical services contract with us, and to accept the contractual reimbursement applicable at the time the contract ended

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

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

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

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

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

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

Continuity of care is not available if:

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

9.4 BENEFITS AVAILABLE FROM OTHER SOURCES

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

9.4.1 Coordination of Benefits (COB)

Coordination of benefits applies when you have healthcare coverage under more than one plan. If you are covered by another plan or plans, the benefits under this Plan and the other plan(s) will be coordinated. This means one plan pays its full benefits first, and then any other plans pay. The Plan follows the order of benefit determination rules in the Oregon Administrative Rules. These rules decide which plan is primary and pays a claim for benefits first. (For coordination with Medicare, see section 9.4.2.)

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

9.4.1.1 When this Plan Pays First

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

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

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

9.4.1.2 How COB Works

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

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

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

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

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

9.4.1.3 Definitions

For purposes of section 9.4.1, the following definitions apply:

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

a. Group or individual insurance contracts and group-type contracts
b. HMO (health maintenance organization) coverage

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

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

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

Plan does not include:
a. Hospital indemnity coverage or other fixed indemnity coverage
b. Accident-only or school accident coverage
c. Specified disease or specified accident coverage
d. Benefits for non-medical components of group long-term care policies
e. Medicare supplement policies
f. Medicaid policies
g. Coverage under other federal governmental plans, unless permitted by law

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

These are not allowable expenses:
a. Any expense that is not covered by any plan covering you
b. Any expense a provider is not allowed to charge you

9.4.2 Coordination with Medicare

We coordinate benefits with Medicare as required under federal law. This includes coordinating to the Medicare allowable amount. To the extent permitted, if the Plan is secondary to Medicare, we 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 you had enrolled in Medicare when eligible. We will estimate what Medicare would have paid and reduce our benefits based on the estimate. If the Plan is secondary to Medicare, we will not pay any expenses incurred from providers who have opted out of Medicare participation.

We may estimate Medicare's payment when:
a. The Plan is a retiree plan
b. You are on COBRA (does not apply to ESRD, below)
c. You are under age 65 and disabled and the group has fewer than 100 employees
d. You have end-stage renal disease (ESRD) and it is during the 30 months after you became eligible to enroll in Medicare

If you choose not to enroll in Medicare when you are first eligible or canceled Medicare after initial enrollment, you may have to pay any expenses not paid by the Plan.

9.4.3 Third Party Liability

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

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

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

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

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

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

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

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

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

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

9.4.3.1 Motor Vehicle Accident Recovery

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

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

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

9.4.4 Surrogacy

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

SECTION 10. ELIGIBILITY & ENROLLMENT

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

The Group's eligibility provisions provide broader dependent eligibility rules for coverage than IRS regulations which govern the Plan. If you elect to enroll a family member who meets the Group's definition of a dependent but DOES NOT meet the IRS definition of a spouse, qualified child, or qualified relative, the payroll deduction for that enrolled dependent's coverage will be taken as a post-tax deduction and you will pay tax on the value of the coverage for that enrolled dependent.

This section explains who is eligible and how to enroll in the Plan. Once covered, it is your responsibility to inform the Group if an enrolled dependent ceases to be eligible due to divorce or other changes in status.

Duration of enrollment is effective for periods no shorter than one month. Exceptions include:

a. partial first month enrollment immediately following the birth of an eligible child, the date of adoption of an eligible child or the date of placement for adoption of an eligible child
b. Extension of Benefits provided by Section 10.8.2
c. partial last month coverage for a subscriber immediately preceding their death.

10.1 SUBSCRIBER

10.1.1 Non-Represented Employees

You are eligible to enroll in the Plan if you work at least 20 hours a week on a regular basis in a temporary (with benefits), regular status, or limited duration Non-Represented position for the Group. You may be eligible to remain covered while on an approved leave of absence under state or federal family and medical leave laws.

10.1.2 Represented Employees

You are eligible to enroll in the Plan if you are covered by any of the labor contracts, and work at least 20 hours a week on a regular basis in a regular status or limited duration position for the Group. You may be eligible to remain covered while on an approved leave of absence under state or federal family and medical leave laws.

10.1.3 Retirees

You may be eligible to continue medical coverage. See the labor agreement or Personnel Rule (for non-represented employee benefits) for retiree requirements and any premium payment obligations. You may be allowed to waive retiree coverage and sign up at a later date if covered continuously by another group plan.

10.1.4 COBRA Eligibility

You may be able to continue coverage under COBRA provisions if you are no longer eligible for coverage under this Plan. You should check with the Group's benefits office to find out whether or not you qualify for COBRA (see Section 11). Benefits under COBRA continuation are the same as the current Plan.

10.2 WHEN AN EMPLOYEE FIRST BECOMES ELIGIBLE

New Hire: A submitted enrollment for you and any dependents to be enrolled must be submitted within 31 days of your date of hire. If enrolling a spouse or domestic partner you must also complete a Declaration of Marriage or Domestic Partnership.

The amount of the employee's share of the monthly premium is different for full-time and part-time employees. Please review the Group's current plan information for the appropriate cost required to participate.

a. If enrollment is submitted within the 31 day enrollment period, **coverage begins on the first of the month on or following enrollment.**
b. If enrollment is not submitted within the 31-day enrollment period, you will be enrolled by default in the Major Medical plan option (or an alternate plan option if specified by labor agreement) provided by the Group with employee only coverage and offered a 15-day period, following the default enrollment, to enroll eligible dependents.

To stay covered by the Plan, you must maintain the minimum FTE employment status required for eligibility. If your job changes, this could affect your eligibility.

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

10.3 DEPENDENTS OF SUBSCRIBERS

Your legal spouse or domestic partner (as defined in the labor agreement between the Union and the County or Personnel Rule for non-represented employee benefits) is eligible for coverage. Your children and children of your spouse or domestic partner are eligible for coverage until their 26th birthday if they meet the eligibility requirements. A child is also eligible if a court or administrative order requires you to provide health coverage. **Eligible dependents must be properly enrolled in order to obtain coverage**. You must accurately report the relationship of all children so it can be determined whether your enrolled children meet IRS criteria as a "child under the age of 27", a qualified child or a qualified relative. Enrolled children who do not meet these criteria may be eligible for coverage but create a tax event for you.

You are responsible for notifying the Group in the event an enrolled dependent ceases to be eligible. Failure to make a timely report of a dependent's loss of eligibility can cause a forfeiture of that dependent's COBRA Continuation of Coverage rights.

For purposes of determining eligibility, the following are considered "children":

a. Children who are under age 26 and are your biological child, step-child, adopted child, child in your custody pending adoption, a child for whom you are required by court order to provide coverage, a child for whom you are a court appointed legal guardian (up to the age of majority, or the age specified by the court), or a biological/adopted child of the domestic partner.

Children with Disabilities
A subscriber's child who has a disability that makes them physically or mentally incapable of self-support is eligible for coverage even when they are over 26 years old, provided that the disability began before the child turned 26. Submit written information from the child's physician showing that the child has an ongoing disability that does not allow them to work to support themself. To

make sure there is not a gap in coverage, we need this information at least 45 days before their 26th birthday. We may ask for more information, such as tax and guardianship information, to confirm the child is eligible for this extended coverage. We will review eligibility from time to time unless the disability is permanent.

10.3.1 New Dependents of Subscribers

Generally you have 60 days from the date you gain a new dependent to complete and submit an enrollment request for that dependent. The following is an explanation of when the new dependent's coverage would begin – if the enrollment is submitted within that enrollment period. Should you fail to submit an enrollment during the enrollment period, or requested supplemental documentation for the dependent is not provided to the Group, you may have to wait until the next annual open enrollment in order to add the new dependent to coverage.

Marriage

If you marry while covered under the Plan, your spouse and their dependent children become eligible for enrollment under the Plan. You must submit enrollment and a Declaration of Marriage or Domestic Partnership. The declaration must be completed, signed electronically, and submitted to the Group during the 60 days immediately following the marriage date. If submitted during the 60 day enrollment period, coverage begins the first of the month on or following the date the Group receives the completed enrollment documentation.

Domestic Partnership – State Registered

State of Oregon Domestic Partner Registry: If you establish a domestic partnership and obtain a certificate from the State of Oregon's Domestic Partner Registry, the domestic partner and their children become eligible for enrollment under the Plan. You must submit enrollment and a Declaration of Marriage or Domestic Partnership. The declaration must be completed, signed electronically and submitted during the 60 days immediately following the domestic partner registration. If submitted during the 60 day enrollment period, coverage begins the first of the month on or following the date the Group receives completed enrollment documentation.

Domestic Partnership – Multnomah County Registered

Multnomah County Domestic Partner Registry: If you establish a domestic partnership and obtain a certificate from the Multnomah County Domestic Partner Registry, the domestic partner and their children become eligible for enrollment under the Plan. You must submit enrollment and a Declaration of Marriage or Domestic Partnership. The declaration must be completed, signed electronically and submitted during the 60 days immediately following the domestic partner registration. If submitted during the 60 day enrollment period, coverage begins the first of the month on or following the date the Group receives completed enrollment documentation.

Domestic Partnership – Shared Residency

Based on Shared Residence: If you establish a domestic partnership and do not obtain a certificate from the Multnomah County Domestic Partner Registry or the State of Oregon's Domestic Partner Registry, the domestic partner and their children become eligible for enrollment under the Plan six months following the date the partnership (and shared residency) commences. However, the six month shared residence period cannot include any period during which either partner was either legally married to another person, or involved in a state registered domestic partnership. In those instances, the six month residency period does not begin until the divorce or dissolution of domestic partnership is finalized. You must submit enrollment and a Declaration of Marriage or Domestic Partnership. The declaration must be completed and signed electronically during the 60 days immediately following the end of the six month residency requirement and submitted to the Group during that period. If submitted during

the 60 day enrollment period, coverage begins the first of the month on or following the date the Group receives completed enrollment documentation.

Newborn Child
Your newborn child is automatically covered under the Plan for 31 days following birth. During this period you must submit enrollment. Enrollment must be submitted to the Group within 60 days of the child's birth. Coverage for the child will terminate after 31 days unless you have submitted a completed enrollment. If enrollment is submitted after coverage is terminated but within 60 days of birth, coverage will be reinstated retroactively with no break in coverage.

Newborn Child Of An Enrolled Child
A newborn of your enrolled child is automatically eligible for coverage under the Plan for 31 days following birth. You should contact the Group within 60 days to request the 31-day enrollment of the newborn.

In certain situations, the newborn may also be eligible for coverage beyond the 31-day period. In addition to the requirements for all child dependents under the Plan, the following conditions must also be satisfied if the newborn is to remain enrolled in the Plan:

a. At the time of birth, the grandchild's birth parent must be unmarried, under age 26, and enrolled as a dependent under the Plan,
b. You must request enrollment for the grandchild within 60 days of birth,
c. The grandchild's birth parent must remain unmarried, under age 26 and otherwise eligible and enrolled for coverage as a dependent under the Plan,
d. Both the grandchild and birth parent reside in the subscriber's home.
e. You must submit an affidavit attesting to these facts to the Group.

A grandchild's continued eligibility for coverage depends on the birth parent. After initial enrollment, a grandchild is only eligible for coverage while all of the conditions listed above remain satisfied. At the time the child's birth parent no longer meets the requirements listed above, the grandchild's eligibility will terminate and coverage will end– *even if the birth parent remains covered*. Should this occur, you would need to obtain legal guardianship of the grandchild in order to retain coverage as a dependent.

Limitations
If you do not submit enrollment for a newborn grandchild within 60 days of birth, the child will lose eligibility for coverage. You would need to obtain legal guardianship of the grandchild in order to enroll the grandchild as a dependent at a later date.

Similarly, if you terminate coverage of a grandchild, you would need to obtain legal guardianship of the grandchild in order to re-enroll the grandchild as a dependent at a later date.

Adopted Child
Adopted children are eligible from the date of the adoption decree. A child who is placed with you pending the completion of adoption proceedings will become eligible on the date of placement. An adopted child or child placed pending adoption is eligible for coverage for 31 days from the date of adoption or date of placement. To begin coverage, the Group must be notified of the adoption and provided with the placement or adoption documentation.

To continue coverage beyond the first 31 days, enrollment is required. The enrollment and any requested supplemental documentation must be submitted to the Group within 60 days of the child's adoption or placement for adoption.

Placement for adoption means you have assumed and retained a legal obligation for full or partial support of the child in anticipation of adoption.

Tax Impact of Dependent Health Benefits
The Group's eligibility rules identifying the dependents who are eligible for enrollment under the Plan are broader than the Internal Revenue Code (IRC) rules identifying dependents who are eligible for tax-free health plan coverage. Passage of the Affordable Care Act (ACA) in 2010 changed the IRC definition of a child specifically for purposes of health plan coverage. The following persons are able to receive tax-favored health coverage within the meaning of the IRC if enrolled by a subscriber:

a. "Children under age 27". "Children under age 27" are:
    i. the taxpayer's biological, adopted, foster or step-children; and
    ii. who as of the end of the taxable year have not attained age 27.
b. "Qualifying Children". Qualifying children are the taxpayer's children by birth, adoption, stepchildren, or foster children who:
    i. are under age 19, or under age 24 in the case of a full-time student, on the last day of the calendar year, or any age if totally disabled; and
    ii. do not provide over one-half of their own support; and
    iii. have the same principal place of residence as the taxpayer for more than six months of the year (temporary absences, such as for school, are treated as time at the same principal place of residence).
c. "Qualifying Relatives". Qualifying relatives are:
    i. the taxpayer's children (by birth, adoption, stepchildren or foster children) of any age who receive over half of their support from the taxpayer and who do not meet the above "Qualifying Child" requirements with respect to any other person;
    ii. or, persons who:
        A. share the taxpayer's residence as a member of the household
        B. who receive over half of their support from the taxpayer; and
        C. who do not meet the above "qualifying child" requirements with respect to any other person.

    Note regarding (C) above: a taxpayer can treat another person's qualifying child as a "Qualifying Relative" if the child satisfies the requirements in (A) and (B) and if the other person is not required to file a tax return and either does not file a return or files one only to get a refund of withheld income taxes. For example, this could allow tax-free health coverage for the children of a taxpayer's non-working domestic partner.

Imputed Income Tax on Non-IRS Eligible Covered Dependents' Benefits
If you are an active employee and have elected to enroll dependents who do not qualify for tax-free health benefits (such as non-spouse partners and some dependent children), the Group will:

a. Establish the fair market value of the Group's contribution for health coverage for these dependents
b. Include this amount in your income when determining income and payroll taxes
c. Report the income on your W-2
d. Withhold employee contributions for these dependents' coverage on a post-tax basis
e. Not permit Health Care Flexible Spending Accounts to be used for the reimbursement of these dependents' uninsured expenses.

10.4 ENROLLING NEW DEPENDENTS OF SUBSCRIBERS

You may obtain coverage for newly acquired or newly eligible dependents by completing enrollment and appropriate Declaration to the Group within 60 days of the eligibility event.

a. If enrollment is submitted during the 60-day enrollment period, **coverage for new Dependent(s) begins on the first of the month on or following enrollment and appropriate Declaration.**
b. If enrollment and any requested supplemental documentation is not submitted during the 60-day enrollment period, you may have to wait until the next annual enrollment period to add the new dependent.

Newborn children, adopted children and children placed for adoption are automatically covered for the first 31 days from birth, adoption or placement for adoption. You must submit enrollment within 60 days of birth, adoption or placement for adoption. Otherwise, coverage for the child will remain terminated on the 31st day post birth, adoption or placement for adoption and you will not be able to re-enroll the child until the next annual open enrollment (see section 10.6).

10.5 OPT-OUT PROVISION

If you certify as covered under another medical plan, you may elect to waive medical/vision/prescription benefits provided by the Group. If you waive medical/vision/prescription coverage, you may still elect dental coverage. You should refer to your labor agreement or Personnel Rule for non-represented employee benefits for details.

If you waive coverage because you have coverage under another group medical plan, you may end your Opt-Out election to enroll in a County health Plan within 60 days of losing the other coverage. Your medical/vision/prescription coverage effective date will be the first day of the month on or following enrollment, appropriate Declaration, and documentation confirming the termination date of the other medical coverage.

10.6 ANNUAL OPEN ENROLLMENT

If you do not enroll a newly acquired dependent within 60 days of the eligibility event, the dependent can be enrolled during the Group's annual open enrollment period.

If you are a newly hired employee and you fail to enroll any dependent within the 31 days following date of hire, you will be able to enroll such dependents during the Group's annual open enrollment period or following a recognized IRS Family Status event, whichever is earlier.

You may not need to wait until the annual open enrollment period to enroll if:

a. You qualify for special enrollment as described in section 10.7
b. A court has ordered you to provide coverage for a spouse/domestic partner or minor child under the subscriber's health benefit plan. You must enroll no more than 60 days after the court order is issued
c. You are employed by an employer who offers multiple health benefit plans and you elect a different health benefit plan during a special open enrollment period
d. Your coverage under Medicaid, Medicare, Tricare, Indian Health Service or a publicly sponsored or subsidized health plan, including but not limited to the Oregon Health Plan,

has been involuntarily terminated within 60 days prior to applying for coverage in a group health benefit plan.

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

10.7 SPECIAL ENROLLMENT

If you lose other coverage or become eligible for a premium assistance subsidy, you have special enrollment rights. Special enrollment applies to both the eligible employee and their spouse/domestic partner if neither is enrolled in the Plan, and either loses other coverage or becomes eligible for a premium assistance subsidy.

To enroll, an eligible employee must submit a complete and signed application and supporting documentation within the required timeframe.

10.7.1 Loss of Other Coverage

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

a. You stated in writing that you already had health coverage when this Plan was first offered to you
b. You ask to enroll no more than 60 days after your prior coverage ended
c. You have a qualifying event. These are:
    i. Your other coverage ended because you were no longer eligible. Examples of when this happens include:
        A. loss of dependent status per plan terms, including divorce or legal separation
        B. dissolution of domestic partnership
        C. end of employment or not working enough hours
        D. reaching the lifetime maximum on all benefits
        E. the plan stops offering coverage to a specific group of similarly situated persons
        F. moving out of an HMO service area and the plan does not have another option
        G. the benefit package option is canceled, and no substitute option is offered
    ii. You were covered under Medicaid or a children's health insurance program (CHIP) and the coverage ended due to loss of eligibility.
    iii. You exhausted your COBRA continuation coverage. This includes reaching the lifetime maximum while on COBRA coverage

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

10.7.2 Payment Changes

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

a. Employer contributions toward your other active coverage (not COBRA coverage) end. You must ask for special enrollment no more than 31 days after the contributions end.

b. If you are covered under Medicaid or CHIP and become eligible for a premium assistance subsidy, you may enroll in the Plan outside of the open enrollment period. You must ask for special enrollment no more than 60 days after becoming eligible.

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

10.7.3 Gaining New Dependents by Subscribers

When you acquire a new dependent through birth, marriage, domestic partnership, adoption or placement of adoption, you, your spouse or domestic partner and children will have special enrollment rights if you are not enrolled at the time of the event that caused you to gain a new dependent.

No waiting period may apply, if enrollment is submitted within the 60-day enrollment opportunity. Coverage would be effective for those eligible to enroll on the following dates:

a. **Marriage:** The date coverage begins is determined by when the enrollment is submitted. Once marriage has occurred, coverage begins the first day of the month on or following the date the Group receives the enrollment and Declaration of Marriage/Domestic Partnership.
b. **Birth:** Infant is automatically covered for the first 31 days following birth. You should complete and submit enrollment. If enrollment is submitted within 60 days of the date of birth, the infant's coverage will be reinstated retroactive to the 31st day post birth.
c. **Adoption or placement for adoption**: Coverage begins on the date of the adoption or the placement date, following enrollment and adoption paperwork.

10.7.4 Qualified Medical Child Support Order (QMCSO)

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

10.8 TERMINATION OF COVERAGE

When the subscriber's coverage ends, coverage for all enrolled dependents also ends unless the dependent/s are eligible for continuation under section 10.8.14 or Section 11.

10.8.1 The Group Plan Ends

Coverage ends for the Group as a whole and members on the date the Plan ends.

10.8.2 Extension of Benefits

When you are an inpatient in the hospital on the day coverage ends, the Plan will continue to pay towards the covered services for that hospitalization until you are discharged from the hospital or benefits have been exhausted, whichever comes first. This exception does not apply to other types of facilities or care.

Benefits will continue to be available, for a limited time, if you are totally disabled and under the care of a physician or surgeon at the time your coverage under the Plan ends. For purposes of this section, "totally disabled" means, when applied to you, that due to a medical condition, you

are prevented from engaging in any work for wage or profit. You will also be considered totally disabled when prevented by a medical condition from engaging in all of your regular activities customary for a person of your age.

The Plan must be given medical proof of the disability and its continuation within 60 days after your coverage ends; and from time to time we can require medical documentation that confirms the continuing disability. Benefits will be available only for expenses incurred in connection with the condition causing the disability. All deductions, payment schedules, and maximums apply.

Benefits will be provided for a period equal to the number of months that you were covered, up to a maximum of 12 months for a subscriber and 6 months for any other member or until the maximum benefit is used, whichever comes first.

These extended benefits are not available in cases when the Plan is terminated or while you are receiving COBRA benefits.

10.8.3 Subscriber Ends Coverage

If you obtain other group health coverage, or are covered as a dependent on other health coverage, you may be able to terminate your coverage with the Group while still actively employed. You will need to submit an enrollment choosing the Opt-Out option, and submit an opt out declaration, within 60 days from the date the new coverage starts. The Plan's coverage end date will be the last day of the month on or following receipt of the completed enrollment change request, or, if the request is received the first of the month, coverage will end on the last day of the prior month.

10.8.4 Death

If a subscriber who is an active employee dies, coverage for any enrolled dependents ends in accordance with the benefit termination rules (event occurring between 1st – 15th of a month causes a coverage end date at the end of that month; event occurring between 16th – 31st of a month causes coverage to end at the end of the following month). Enrolled dependents may extend their coverage for up to 36 months if the requirements for continuation of coverage (COBRA) are met (see Section 11).

If a retired subscriber dies, coverage for any enrolled dependents ends at the end of the month. Enrolled dependents may extend their coverage for up to 36 months if the requirements for continuation of coverage (COBRA) are met (see Section 11 for details).

If a covered COBRA subscriber dies, coverage for any enrolled dependents ends at the end of the month. Enrolled dependents may extend their coverage for up to 36 months (measured from the original COBRA event date) if the requirements for continuation of coverage (COBRA) are met (see Section 11 for details).

If any subscriber dies, and the subscriber's legal spouse or domestic partner (when partnership is registered with the State of Oregon) is age 55 or older at the time of death, the enrolled legal spouse or State registered Domestic Partner, and any enrolled dependent children under the Plan may continue their coverage under the Plan if they meet the requirements in section 10.8.14.

10.8.5 Loss of Eligibility

If you are no longer eligible, coverage will end for you and any enrolled dependents according to the terms described in the labor agreement or Personnel Rule for non-represented employee

benefits. However, you and enrolled dependents may have the right to continue coverage by purchasing the coverage on your own. See the "Continuation of Coverage" section.

10.8.6 Rescission

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

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

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

The Plan has the right to keep any premiums paid as liquidated damages. You will have to repay any benefits that have been paid. You will be told of a rescission 30 days before your coverage is canceled.

10.8.7 Family & Medical Leave

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

If you are unpaid during a period of leave, your cost shares will be recovered by the Group upon your return to work.

10.8.8 Leave of Absence

If you are granted a non- Family Medical Leave Act/Oregon Family Leave Act/Paid Leave Oregon/Washington Paid Family and Medical Leave leave of absence by the Group, group sponsored coverage will end after the initial 30 days of leave, unless you return to work for the Group. If 30 days after the last day in paid status falls between the 1st and 15th of a month – the coverage end date is the last day of the same month. If 30 days after the last day in paid status falls between the 16th and the last day of a month – the coverage end date is the last day of the following month. Once the group sponsored coverage ends, you and any enrolled dependents may continue coverage under the Plan by purchasing the coverage on your own (see Section 11).

A leave of absence is a period off work granted by the Group during which you are still considered to be employed and are carried on the employment records of the Group.

10.8.9 Strike or Lockout

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

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

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

10.8.10 Termination of Employment

If your active employment terminates with the Group, coverage will end for you and all enrolled dependents. If the employment termination date falls between the 1st and 15th of a month – the coverage end date is the last day of the same month. If the employment termination date falls between the 16th and the last day of a month – the coverage end date is the last day of the following month. You may have the opportunity to continue coverage under the Plan (see section 10.1.3 or Section 11).

Should your active employment with the Group end, then you are rehired by the Group and return to active work within the same plan year:

If no open enrollment period has occurred during your absence: You and any previously enrolled dependents will be re-enrolled under the previous elected group health plan. Coverage will begin on the first of the month on or following your rehire date.

If you have experienced a family status change during the leave, or return to work at a different FTE or Bargaining Unit: you may be able to request a change to the previous benefit elections (you can contact the Group for more information.)

If an open enrollment period occurred during your absence: You must complete and submit a Benefit Enrollment, as explained in the New Hire section, in order to enroll and initiate coverage. In this situation, you have the option of changing previous plan elections or keeping the same elections but the enrollment submission is required.

10.8.11 Termination of Coverage due to Reduction in Hours

If you experience a reduction in hours that causes loss of coverage, and subsequently experience an increase in work hours allowing you to qualify for benefits again:

If no open enrollment period has occurred during the period of non-coverage: You and any previously enrolled dependents will be re-enrolled under the previously elected group health plan. Coverage will begin on the first of the month on or following the date you become eligible for coverage again.

If you have experienced a family status change during the period of non-coverage or are working at a different FTE or Bargaining Unit: You may be able to request a change to the previous benefit elections (you can contact the Group for more information.)

If an open enrollment period occurred during the period of non-coverage: You must complete and submit a Benefit Enrollment in order to enroll and initiate coverage. In this situation, you have the option of changing your previous plan elections or keeping the same elections, but the enrollment submission is required.

If you have unpaid employee cost shares remaining from a prior period of employment, they will be recovered by the employer upon your return to work to the extent permitted by law.

The Group must notify Moda Health that you are being rehired following a termination of employment or your hours have been increased.

All Plan provisions will resume at the time you re-enroll whether or not there was lapse in coverage.

10.8.12 Loss of Eligibility by Children

An enrolled child will lose eligibility when one of these events occurs (whichever occurs first):

a. the child reaches age 26
b. stepchild relationship ends due to divorce or end of domestic partnership
c. The child reaches the age of majority or the age specified by the court, if the child is under legal guardianship of the subscriber
d. A grandchild ceases to meet the eligibility requirements specified in section 10.3
e. A child with disability ceases to meet the eligibility requirements specified in section 10.3.

Coverage will end on the last day of the month in which the child's eligibility ends. You will need to submit a timely request for the enrolled dependent's removal from coverage to the Group. You (or the dependent) may have the option to continue the dependent's coverage for up to 36 months by purchasing the coverage if the former dependent meets the requirements listed in Section 11.

10.8.13 Loss of Eligibility by A Spouse or Domestic Partner

Coverage ends for an enrolled spouse or a domestic partner on the last day of the monthly period in which a decree of divorce or annulment is entered (regardless of any appeal) or domestic partnership is ended. However, you (or the spouse/domestic partner) have the option to continue the spouse/domestic partner's coverage for up to 36 months by purchasing the coverage if the former spouse/domestic partner meets the requirements listed in Section 11.

Note

It is your responsibility to report an enrolled dependent's loss of eligibility in a timely manner. Failure to report a loss of eligibility event in a timely manner can cause a forfeiture of the terminated dependent's COBRA eligibility and, if benefit overpayment occurs, a financial responsibility for you.

10.8.14 Oregon Continuation Coverage for Spouses or State Registered Domestic Partners Age 55 and Over

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

You must notify the Group or its third party administrator in writing within 60 days from the date your marriage or domestic partnership is legally ended or within 30 days after the subscriber has died. Include your mailing address. Notify the Group at:

Multnomah County – Employee Benefits Office
501 S.E. Hawthorne Blvd. Suite 320
Portland, OR 97214

You will be given information about how to sign up for continuation coverage and pay premiums. If you do not elect 55+ Continuation on time, you will lose the right to this continuation coverage.

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

For 55+ Continuation, the term “domestic partner” refers only to a State registered domestic partner, as defined in Section 12.

10.8.15 Uniformed Services Employment & Reemployment Rights Act (USERRA)

If you are called to active duty by any of the armed forces of the United States of America, you may continue coverage under USERRA for up to 24 months or the period of uniformed service leave, whichever is shortest. You must continue to pay your share of the premiums during the leave.

If you do not elect continued coverage under USERRA, or you cancel or use up your USERRA continuation, coverage restarts on the day you return to active employment with the Group. All plan provisions and limitations apply as if your Plan coverage had been continuous. You must be released under honorable conditions, and return to active employment within the required timeframe. You can get complete information about your rights under USERRA from the Group.

SECTION 11. CONTINUATION OF HEALTH COVERAGE

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

11.1 COBRA CONTINUATION COVERAGE

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

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

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

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

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

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

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

Multnomah County – Employee Benefits Office
501 S.E. Hawthorne Blvd. Suite 320
Portland, OR 97214
employee.benefits@multco.us

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

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

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

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

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

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

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

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

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

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

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

Note: Longer continuation coverage may be available under Oregon Law for a subscriber's spouse or Oregon state domestic partner age 55 and older who loses coverage due to the subscriber's death, or due to legal separation or dissolution of marriage or domestic partnership (see section 10.8.14).

Newborn or Adopted Child
If a child is born to or placed for adoption with you, the child is considered a qualified beneficiary. You may elect continuation coverage for the child provided the child satisfies the otherwise applicable Plan eligibility requirements (for example, age). You or a family member must notify the COBRA Administrator within 60 days of the birth or placement to obtain continuation coverage. Enrollment of an additional dependent may increase the cost of coverage. If the COBRA Administrator is not notified in the required time, the child will not be eligible for coverage.

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

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

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

When COBRA continuation coverage ends, members will be provided with a Certificate of Creditable Coverage, which includes the period of coverage each member had under the COBRA continuation of coverage option.

Members should notify the COBRA Administrator if there is a changed marital status, a change of addresses, or other changes that may impact eligibility for COBRA continuation coverage.

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

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

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

SECTION 12. DEFINITIONS

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

Authorization see Prior Authorization.

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

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

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

Claim Determination Period means a plan year or portion thereof.

Coinsurance is a percentage of covered expense that you pay. If your coinsurance is 15%, you pay 15% of the covered charge and we pay the other 85%.

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

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

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

Custodial Care means care that helps you conduct common activities such as bathing, eating, dressing, getting in and out of bed, preparation of special diets and supervision of medication that usually can be self-administered. It is care that can be provided by people without medical or paramedical skills. Custodial care also includes care that is primarily for the purpose of separating you from others, or for preventing you from harming yourself.

Deductible is the amount of covered expenses you must pay before the Plan starts paying.

Dental Accident means an accidental injury to natural teeth (see section 7.4.9 for explanation of coverage).

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

Dental Implant means a device specially designed to be placed surgically within or on the mandibular or maxillary bone as a means of providing for dental replacement; endosteal (endosseous); eposteal (subperiosteal); transosteal (transosseous).

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

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

a. **State Registered Domestic Partner** is a person joined with the subscriber in a partnership that has been registered in Oregon under the Oregon Domestic Partner Registry according to the Oregon Family Fairness Act
b. **Not State Registered Domestic Partner** means a person who is not married or registered in Oregon under the Oregon Family Fairness Act, and has entered into a partnership with you that meets the criteria in the Group's declaration of domestic partnership

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

Eligible Dependent means any person who is eligible for coverage under the terms of the Plan because of a relationship to a subscriber.

Eligible Employee refers to any person who meets all of the following criteria:

a. is a permanent employee of the Group
b. is not a seasonal, substitute, or an agent, consultant or independent contractor
c. is paid on a regular basis through the payroll system, has federal taxes deducted from such pay, and is reported to Social Security
d. works for the Group on a regularly scheduled basis at least 20 hours per week
e. meets the eligibility requirements specified in section 10.1.1 or 10.1.2

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

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

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

medical examination and treatment required to stabilize a member and within the capabilities of the staff and facilities available at the hospital, are included.

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

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

Enrolled Dependent means a person who is an eligible dependent of a covered, enrolled employee of the Group or an eligible dependent of an enrolled retiree of the Group, who has elected to enroll the dependent in the Plan, and whose enrollment has been submitted.

Enrollment Date means, for new hires and others who enroll when first eligible, the date coverage begins.

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

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

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

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

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

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

Implant is a material inserted or grafted into tissue.

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

In-Network refers to providers such as hospitals, professional providers, chemical dependency treatment programs and facilities contracted under one of our approved networks to provide care to you.

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

MPA for an out-of-network provider is the lesser of the amount payable under any supplemental provider fee arrangements Moda Health may have in place and the 75th percentile of fees commonly charged for a given procedure in a given area, based on a national database.

If a dollar value is not available in the national database, Moda Health will consider 75% of the billed charge as the MPA. The remaining 25% over the MPA is the member's responsibility along with any amounts applied to deductible or coinsurance.

In certain instances, when a dollar value is not available in the database, the claim is reviewed by Moda Health's medical consultant, who determines a comparable code to the one billed. Once a comparable code is established, the claim is processed as described above.

In each of the above situations relating to an out-of-network provider, any amount above the MPA is the member's responsibility. Depending upon the plan provisions, deductibles and copayments or coinsurance may also apply.

MPA for medical devices, including implanted devices, and for durable medical equipment is the contracted amount, or the lesser of 100% of the Medicare allowable amount or the acquisition cost of the device plus 10% if there is no contracted amount.

MPA for out-of-network dialysis facilities is 125% of the Medicare allowable amount.

Reimbursement for medications dispensed by providers other than pharmacies will be subject to benefit provisions of the Plan and paid based on the lesser of either the average wholesale price (AWP) or billed charges.

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

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

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

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

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

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

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

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

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

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

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

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

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

Out-of-Network refers to providers such as professional providers, chemical dependency treatment programs and facilities that are not contracted under one of our approved networks to charge discounted rates to you. They will be reimbursed based on the MPA for the service provided.

Out-of-Pocket Maximum is the maximum amount you pay out-of-pocket every year. It includes the deductible, coinsurance and copays. If you reach the out-of-pocket maximum in a plan year, the Plan will pay 100% of your eligible expenses for the rest of the year.

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

Plan Sponsor is the Group.

Plan Year refers to a twelve month period beginning on January 1 and ending on December 31. The deductible and separate out-of-pocket maximums for the medical benefits covered under the Plan and the separate out-of-pocket maximum for prescription medication expenses covered under a separate plan shall be accrued on a plan year or annual basis.

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

Prior Authorization or **Prior Authorized** refers to getting approval from us before the date of service. A complete list of services and medications that require prior authorization is available on your Member Dashboard or you can ask Moda Health Customer Service. A service, supply or medication that is not prior authorized when required will not be covered or you will have a benefit penalty (see Section 6 for medical authorization and section 7.6.7 for prescription medication authorization).

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

Prosthetic Device as defined by state law is an artificial limb device or appliance designed to replace in whole or in part an arm, a leg, a foot, or a hand.

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

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

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

SECTION 13. GENERAL PROVISIONS & LEGAL NOTICES

13.1 MEMBER DISCLOSURES

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

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

You have the responsibility to:

a. Read this handbook and make sure you understand the medical and prescription medication plans. You should call Moda Health Customer Service, WellDyneRx Customer Service, VSP Customer Service or Multnomah County Benefits Office if you 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 you will be late or need to cancel
d. Get regular health checkups and preventive services
e. Give your provider all the information they need to provide good healthcare to you
f. Participate in making decisions about your medical care and forming a treatment plan
g. Follow plans and instructions for care you have agreed to with your provider
h. Use urgent and emergency services appropriately
i. Show your medical ID card when seeking medical care
j. Tell providers about any other insurance policies that may provide coverage
k. Reimburse the Plan from any third party payments you may receive
l. Provide information we need to properly administer benefits and resolve any issues or concerns that may arise

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

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

How will I know if my benefits change or end?
The Group will notify you if your benefits change or your coverage is terminated. If the policy ends and the Group does not replace the coverage with another group policy, the Group is required by law to inform its members in writing of the termination.

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

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

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

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

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

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

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

If I am not satisfied with the plan, how can I file an appeal or complaint?
You can file an appeal or complaint by writing a letter to Moda Health. Customer Service can help you if needed. Appeals on prescription medication benefits should be submitted to WellDyneRx (P.O. Box 90369, Lakeland, FL 33804). Appeals on vision care benefits should be submitted to VSP Member Appeals at 3333 Quality Drive, Rancho Cordova, CA 95670 or call 800-877-7195 (see section 7.7.7 for info related to vision care appeals). Complete information is in section 9.2.

A member may also ask for help from the Multnomah County Employee Benefits Office for questions about their appeal rights or for assistance:

Multnomah County Employee Benefits Office
501 SE Hawthorne, Suite 320
Portland, OR 97214
Telephone: 503-988-3477
FAX: 503-988-6257

Email: employee.benefits@multco.us

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

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

13.2 GENERAL & MISCELLANEOUS PROVISIONS

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

Confidentiality of Member Information
Keeping your protected health information (PHI) confidential is very important to us. PHI includes enrollment, claims, and medical and dental information. We use this information to pay your claims and authorize services. It is also used for referrals, case management and quality management programs. We do not sell your information. The Group's Notice of Privacy Practices has more detail about how we use your PHI. Contact the Group if you have other questions about privacy.

Right to Collect & Release Needed Information
You must give Moda Health, WellDyneRx and VSP, or authorize a provider to give Moda Health, WellDyneRx and VSP, any information they need to pay benefits. Moda Health, WellDyneRx and VSP may release to or collect from any person or organization any needed information about you.

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

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

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

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

No Waiver
Any waiver of any provision of the Plan or any performance under the Plan must be in writing and signed by the waiving party. Any such waiver shall not operate as, or be deemed to be, a waiver of any prior or future performance or enforcement of that provision or any other provision. If Moda Health, WellDyneRx or VSP delay or fail to exercise any right, power or remedy provided in the Plan, including a delay or omission in denying a claim, that shall not waive Moda Health's rights to enforce the provisions of the Plan.

Group is the Agent
The Group is the member's agent for all purposes under the Plan. The Group is not the agent of Moda Health, WellDyneRx or VSP.

Responsibility for Quality of Medical Care
You always have the right to choose your provider. Neither the Plan nor Moda Health, WellDyneRx or VSP are responsible for the quality of your medical care. Your providers act as independent contractors. Neither the Plan nor Moda Health, WellDyneRx or VSP can be held liable for any injuries you get while receiving medical services or supplies.

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

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

Where any Legal Action Must be Filed
Any legal action arising out of the Plan must be filed in either state or federal court in the state of Oregon.

Time Limits for Filing a Lawsuit
Any legal action arising out of, or related to, the Plan and filed against the Plan by a member or any third party, must be filed in court no more than 3 years after the time the claim was filed (see section 9.1). All internal levels of appeal under the Plan must be exhausted before filing a legal action in court.

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

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

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

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

Nondiscrimination notice

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

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

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

If you need any of the above, call:

888-217-2363 (TDD/TTY 711)

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

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

Scott White coordinates our nondiscrimination work:

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

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

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

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

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

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

modahealth.com

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

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

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

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

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

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

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

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

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

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

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

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

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

For help, call us directly at 888-445-7413
(En español: 888-786-7461)