Oregon Group Medical Plan

Platinum Plan

Effective date: January 1, 2020

Classes: 0002, 0011 and 0013

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

This handbook describes the main features of the medical plan (the "Plan"), the vision care plan and the prescription medication plan provided by Multnomah County (also known as the Group), but does not waive any of the conditions of the Plan as set out in the Plan Document.

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

Funding Medium and Type of Plan Administration: 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 a subscriber pays toward the total contribution is determined by the Group and the subscriber's bargaining unit.

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

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

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

SECTION 2. MEMBER RESOURCES

2.1 CONTACT INFORMATION

Moda Health Website (log in to myModa)
www.modahealth.com
Includes many helpful features, such as:

- Find Care (use to find an in-network provider)
- Prior authorization lists (services and supplies that may require authorization) www.modahealth.com/medical/referrals

Medical Customer Service Department
1-888-445-7413
En Español 1-888-786-7461
Dental Customer Service Department
1-888-447-8194
En Español 1-877-299-9063

Behavioral Health Customer Service Department
1-800-799-9391

Disease Management and Health Coaching
1-877-277-7281

Hearing Services Customer Service Department
866-202-2178

Pharmacy Customer Service
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

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 MEMBERSHIP CARD

After enrollment, members will receive ID identification cards that include the group and identification numbers. Members will need to present the card each time they receive services. **Members may go to myModa or contact Moda Health Customer Service for replacement of a lost ID card.**

2.3 NETWORKS

See Network Information (Section 3) for more detail about how networks work.

Medical network
Connexus

Pharmacy network
WellDyneRx

Vision Care network
VSP Choice Network

2.4 CARE COORDINATION

2.4.1 Care Coordination

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

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

2.4.2 Disease Management

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

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

Contact Disease Management and Health Coaching for more information.

2.4.3 Behavioral Health

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

2.5 OTHER RESOURCES

Additional member resources providing general information about the Plan can be found in Section 10, Section 11 and Section 16.

SECTION 3. NETWORK INFORMATION

In-network benefits apply to services delivered by in-network providers; out-of-network benefits apply to services delivered by out-of-network providers. By using the services of an in-network provider, members will receive a higher level of benefits.

When receiving care at an in-network facility, remember to ask that any lab work, x-rays and other ancillary services (such as anesthesiology, surgical assistants) be performed by in-network providers and facilities to ensure the highest benefit level.
When the member is at an in-network facility and is not able to choose the provider, in-network cost sharing will apply to services by out-of-network providers, and an Oregon-licensed provider cannot balance bill the member except when permitted by law.

Members may choose an in-network medical provider by using "Find Care" on myModa or by contacting Moda Health Customer Service for assistance. Member ID cards will identify the applicable networks.

3.1 GENERAL NETWORK INFORMATION

3.1.1 Primary Network; Primary Service Area

All members have access to a primary network, which provides services in the Group's primary service area. Members who live inside the in-network service area who receive covered services from an out-of-network provider or who live or travel outside the in-network service area will be paid at the out-of-network benefit level.

Members should ask if their medical provider (both professional provider and facility) is participating with the specific networks listed below. Do not ask if the provider accepts Moda. There are many Moda Health networks. A provider may accept Moda insurance, but not be participating with the network for the Plan.

Members may choose an in-network provider by using "Find Care" on myModa or by contacting Moda Health Customer Service for assistance.

Provider Networks
Medical network is Connexus Network
Pharmacy network is WellDyneRx
Vision care network is VSP Choice Network

3.1.2 Out-of-Network Care

When members choose healthcare providers that are not in-network, the benefit from the Plan is lower, at the out-of-network level described in section 4.1. In most cases the member must pay the provider all charges at the time of treatment, and then file a claim to be reimbursed the out-of-network benefit. If the provider's charges are in excess of the maximum plan allowance, the member may be responsible for paying those excess charges.

If a member chooses to receive services from an out-of-network provider, benefits will be at the out-of-network level and the member will have to pay any amount over the maximum plan allowance.

3.1.3 Care After Normal Office Hours

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

SECTION 4. SUMMARY OF BENEFITS

This section is a quick reference summarizing the medical and prescription medication benefits.

It is important to also check the Benefit Description (Section 8) for more details about any limitations or requirements. Link directly there from the Details column.

The details of the actual benefits and the conditions, limitations and exclusions are contained in the sections that follow. **Benefits are paid based on a PLAN YEAR – January through December.**

Prior authorization may be required for some services (see Section 6). An explanation of important terms is found in Section 5.

4.1 SCHEDULE OF BENEFITS FOR MEDICAL AND PRESCRIPTION BENEFITS

Cost sharing is the amount members pay. For services provided out-of-network, members may also be responsible for any amount in excess of the maximum plan allowance except as stated in section 3.1.2.

All "annual" or "per year" benefits accrue on a plan year basis (from January 1st to December 31st) unless otherwise specified.

Plan Design	In-Network Benefits	Out-of-Network Benefits
Annual Deductible per Member	**$300**	
Maximum Annual Deductible per Family	**$900**	
Annual Medical Out-of-Pocket Maximum per Member (includes deductible and does not include prescription out of pocket costs)	**$1,900**	
Annual Medical Out-of-Pocket Maximum per Family (includes deductible and does not include prescription out of pocket costs)	**$5,700**	
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	Member Cost Share (Deductible applies unless noted differently)		Section in Handbook & Details
	In-network	Out-of-network	
Ambulance Transport			
Ambulance Transportation	15%	15%	Section 8.2
Emergency & Urgent Care			
Emergency Room Facility	$100 per visit, then 15%	$100 per visit, then 15%	Section 8.3.1 Copay waived if covered hospitalization immediately follows emergency room use
ER professional or ancillary services billed separately	15%	15%	
Urgent care	15%	35%	Section 8.3.2
Hospice Care			
Home Care	No cost sharing	35%	Section 8.4.2
Inpatient Care	No cost sharing	35%	Section 8.4.3
Respite Care	No cost sharing	35%	Section 8.4.4 120 hours
Hospital Care and Residential Facility Care			
Chemical Dependency Detoxification	15%	35%	Section 8.5.1
Diagnostic Procedures, including x-ray and lab	15%	35%	Section 8.6.4
Hospital Acute Care	15%	35%	Section 8.5.3
Rehabilitation and Habilitation (Physical, occupational and speech therapy)	15%	35%	Section 8.5.6 Confinement must begin within one year of onset of the condition
Residential Mental Health & Chemical Dependency Treatment Programs	15%	35%	Section 8.5.7
Skilled Nursing Facility Care	15%	35%	Section 8.5.8 100 days per plan year
Medications			
Anticancer Medications	20%, up to $50 maximum	20%, up to $50 maximum	Section 8.9.2 No deductible

Services	Member Cost Share (Deductible applies unless noted differently)		Section in Handbook & Details
	In-network	Out-of-network	
Prescription Medications			Section 8.10 No deductible
Retail Pharmacy			Up to 30-day supply
Value Tier	20%, up to $4 maximum	20%, up to $4 maximum	
Tier 1 Select	20%, up to $50 maximum	20%, up to $50 maximum	
Tier 2 Preferred	20%, up to $50 maximum	20%, up to $50 maximum	
Tier 3 Non-Formulary	50%	50%	
Mail Order Pharmacy			Up to 90-day supply per prescription
Value Tier	20%, up to $8 maximum	N/A	
Tier 1 Select	20%, up to $30 maximum	N/A	
Tier 2 Preferred	20%, up to $125 maximum	N/A	
Tier 3 Non-Formulary	50%	N/A	
Specialty Pharmacy			Up to 30-day supply
Tier 1 Select	20%, up to $50 maximum	N/A	
Tier 2 Preferred	20%, up to $50 maximum	N/A	
Tier 3 Non-Formulary	50%	N/A	
Outpatient Services			
Anticancer Medications	20%, up to $50 maximum	20%, up to $50 maximum	Section 8.9.2 No deductible
Chemical Dependency Services	15%	35%	Section 8.6.2
Diagnostic Procedures, including x-ray and lab	15%	35%	Section 8.6.4
Imaging Procedures	15%	35%	
Infusion Therapy			Section 8.6.5
Home Infusion	15%	35%	
Outpatient Infusion	15%	35%	

Services	Member Cost Share (Deductible applies unless noted differently)		Section in Handbook & Details
	In-network	Out-of-network	
Kidney Dialysis	15%	35%	Section 8.6.6
Outpatient Surgery and Invasive Diagnostic Procedures (Facility Charges)	15%	35%	Section 8.6.7
Rehabilitation and Habilitation (Physical, occupational and speech therapy)	15%	35%	Section 8.6.8 60 sessions per plan year, except as required for mental health parity
Therapeutic Radiology	15%	35%	Section 8.6.9
Professional Services			
Acupuncture Care	15%	35%	Section 8.7.1 20 visits per plan year
Alternative Care (Spinal Manipulation, Naturopathic Substances and Massage Therapy)	50% (deductible waived)	50% (deductible waived)	Section 8.7.2 $350 aggregate plan year maximum
Applied Behavior Analysis			Section 8.7.3
Office Visits	15%	35%	
Other Services	15%	35%	
Dental Care (treatment following dental accident only)	15%	35%	Section 8.7.8
Diabetes Services			Section 8.7.9
Diabetes Self-Management Programs (including pre-diabetes condition)	No cost sharing	No cost sharing	
Other medical services	15%	35%	Insulin and diabetic supplies covered under the pharmacy prescription benefit (section 8.10.4)
Hearing Exams for Enrolled Adults (Age 26+)	15%	35%	Section 8.7.11 Once per plan year
Hearing Aids for Enrolled Adults (Age 26+)	50%	50%	Section 8.7.11 $4,000 maximum every 48 months

Services	Member Cost Share (Deductible applies unless noted differently)		Section in Handbook & Details
	In-network	Out-of-network	
Hearing Exams for Members up to age 26	15%	15%	Section 8.7.12 Twice per plan year for under age 4 and once per plan year for age 4 to 26
Hearing Aids and Related Services (Mandated Benefits for Members up to age 26)	15%	35%	Section 8.7.13 Once every 3 plan years, other limits apply for batteries and ear molds
Home and Office Visits	15%	35%	Section 8.7.20
Infertility Diagnosis	15%	35%	Section 8.7.15 Up to $10,000 lifetime limit
Mental Health Services	15%	35%	Section 8.7.17
Physician Hospital Visits	15%	35%	Section 8.5.4
Preventive Services			Section 8.7.22
Services as required under the Affordable Care Act, including the following:	No cost sharing	Not covered unless otherwise stated	
Preventive Health Exams	No cost sharing	35% (deductible waived)	Page 39 6 visits in first year of life 7 exams from age 1 to 4 One per plan year, age 5+
Immunizations	No cost sharing	No cost sharing	Page 40
Women's Exam & Pap Tests	No cost sharing	35%	Page 40 One per plan year
Mammogram	No cost sharing	35%	Page 40 One per plan year, age 40+
Colonoscopy	No cost sharing	35% (deductible waived)	Page 40 One per 10 plan years, age 50+
Well-Baby Exams	No cost sharing	35% (deductible waived)	Page 39
Pediatric Screenings	No cost sharing	Not covered	Page 42 Age/frequency limits apply
Preventive Diagnostic X-ray & Lab	No cost sharing	35% (deductible waived)	Page 39
Other preventive services, including:			
Diagnostic X-ray & Lab	15% (deductible waived)	35% (deductible waived)	Page 39

Services	Member Cost Share (Deductible applies unless noted differently)		Section in Handbook & Details
	In-network	Out-of-network	
Prostate Rectal Exam	No cost sharing	35% (deductible waived)	Page 40 One per plan year, age 50+
Prostate Specific Antigen (PSA) Test	No cost sharing	35% (deductible waived)	Page 40 One per 12 month period, age 50+
Surgery	15%	35%	Section 8.7.25
Temporomandibular Joint Syndrome (TMJ)	15%	35%	Section 8.7.27 $1,500 lifetime maximum
Therapeutic Injections	15%	35%	Section 8.7.28
Tobacco Cessation Treatment			Section 8.7.29
Consultation	No cost sharing	No cost sharing	
Supplies	No cost sharing	No cost sharing	
Prescription Medications	No cost sharing	No cost sharing	Prescriptions may be purchased at any pharmacy
Other Services			
Biofeedback	15%	35%	Section 8.8.1 Up to 10 lifetime visits
Breastfeeding			Section 8.8.2
Support, and Counseling	No cost sharing	35%	
Supplies	No cost sharing	No cost sharing	
Durable Medical Equipment (DME), Supplies & Appliances – Outpatient	15%	35%	Section 8.8.3
Home Healthcare & Skilled Nursing Care	15%	35%	Section 8.8.3 Requires authorization. 60 visits per plan year
Maternity	15%	35%	Section 8.8.5
Supplies and Appliances	15%	35%	Section 8.8.3
Transplants			Section 8.8.7
Center of Excellence Facilities	15%	N/A	
Other Facility	Not covered	Not covered	
Donor Costs			
Center of Excellence Facilities	15%	N/A	
Other Facilities	Not covered	Not covered	

Services	Member Cost Share (Deductible applies unless noted differently)		Section in Handbook & Details
	In-network	Out-of-network	
Vision care and treatment of the eye			
Routine exam and hardware	See separate VSP schedule	See separate VSP schedule	Section 8.11
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.
Eyewear after cataract surgery	15%	35%	Section 8.8.3
Eyewear for the diagnoses of aphakia or keratoconus	15%	35%	Section 8.8.3
Annual dilated eye exam or retinal imaging for diabetes screening	15%	35%	Section 8.7.9
Wigs	15%	35%	Section 8.8.3 Once per plan year

4.2 MEDICAL DEDUCTIBLE

The Plan has a deductible effective January 1st through December 31 each year. The amount of the medical deductible is shown in section 4.1. The medical deductible applies separately to each member, but no family will be required to satisfy more than the total family medical deductible as shown in section 4.1, no matter how many members are in the family. The Plan does not pay any medical benefits until the medical deductible is satisfied, unless otherwise noted. That means the member pays the full cost of services that are subject to the deductible until he or she has spent the deductible amount. Then the Plan begins sharing costs with the member. The Plan pays some services before the deductible is met. See section 4.1 for details. Expenses applied towards the plan year medical deductible also apply to the plan year medical out-of-pocket maximum. This deductible does not include prescription drug costs, disallowed charges and copayments.

If covered expenses incurred in the last three months of a plan year are applied toward the medical deductible for that year, they will be carried forward and applied toward the medical deductible for the following year. This is commonly referred to as the deductible carryover.

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.

4.3 PLAN YEAR MEDICAL MAXIMUM OUT-OF-POCKET

Once the medical deductible is satisfied, the Plan will pay a percentage of the covered medical expenses described below. See section 4.1 for exceptions when services are paid at a different percentage.

The Plan will pay a percentage of covered expenses:

a. Out-of-network providers: 65%(*) of maximum plan allowance, or
b. In-network providers: 85% of contracted fees

The remaining 35% for out-of-network providers or 15% for in-network providers of the covered expense is the amount which the member must pay. This is referred to as the out-of-pocket expense. This out-of-pocket expense does not include prescription drugs.

Once a member's medical out-of-pocket expenses accumulate to the $1,900 annual medical out-of-pocket maximum (which does not include the out-of-pocket expenses for adult hearing aids, non-covered expenses, or penalties) in any year, the Plan will pay 100% of covered medical expenses in excess of the out-of-pocket maximum incurred by that member during the remainder of the year.

The annual medical out-of-pocket maximum for the family is $5,700.

a. When a member living inside the in-network service area receives covered services from an out-of-network provider because the in-network panel does not include such services, payment will be 85% of maximum plan allowance of covered expenses after the deductible. The amount which the member must pay is the remaining 15%, expenses applied to the deductible, and the any portion of the charge in excess of maximum plan allowance except as stated in section 3.1.2.
b. For members living or traveling outside the in-network service area, payment will be 65% of maximum plan allowance of covered expenses after the deductible. The amount which the member must pay is the remaining 35%, expenses applied to the deductible, and any portion of the charge in excess of maximum plan allowance.

4.4 PLAN YEAR PRESCRIPTION MAXIMUM OUT-OF-POCKET

Each member per year..... $2,000 for value, select, preferred, and non-formulary medications
Each family per year..... $6,000 for value, select, preferred, and non-formulary medications

After a member reaches the annual prescription out-of-pocket maximum, the prescription plan will pay 100% of the covered expense for value, select, preferred, and non-formulary medications (based upon the WellDyneRx Preferred Drug List) for prescription medication purchases made at participating in-network pharmacies for the member for the remainder of that year. The medical plan out-of-pocket expenses, the medical plan deductible, manufacturer discounts and/or copay

assistance programs and medical non-covered expenses do not accumulate toward this prescription maximum.

4.5 PAYMENT

Expenses allowed by the Plan are based upon the contracted fees for services rendered by in-network providers and the maximum plan allowance for services of out-of-network providers. The maximum plan allowance for out-of-network providers is established, reviewed, and updated by a national database (see Section 5 for details).

Except for cost sharing and plan benefit limitations, in-network providers agree to look solely to the Plan, if the Plan is paying an in-network provider, for compensation of covered services provided to members.

4.6 MEDICARE

Expenses covered by Medicare (Parts A and B) are subject to Coordination of Benefits (see sections 10.5 and 11.6 for details). Payable medical benefits under the Plan will be paid based upon an estimate of the Medicare benefit under Part B for members who are eligible for Medicare (Parts A and B) but have declined Medicare (Parts A and B) enrollment and whose plan coverage by law is secondary to Medicare.

4.7 EMERGENCY CARE

Members are covered for emergency services worldwide. A member who believes he or she has a medical emergency should call 9-1-1 or seek care from the nearest appropriate provider, such as a physician's office or clinic, urgent care facility or emergency room. See Section 5 for the definition of emergency medical condition and section 8.3 for emergency services coverage.

SECTION 5. DEFINITIONS

The following are definitions of some important terms used in this handbook. Some other terms are defined where they are used. See section 8.11.1 for additional definitions for vision care benefits.

Affidavit of Marriage or Domestic Partnership is a signed document that attests the subscriber and one other eligible person meet the criteria in the affidavit to be a spouse or not state registered domestic partner. Document is required by the Group from every employee who seeks to enroll a spouse or domestic partner for health plan coverage.

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

Applied Behavior Analysis means a variety of psychosocial interventions that use behavioral principles to shape an individual's behavior. It includes direct observation, measurement and functional analysis of the relationship between environment and behavior. It is a type of treatment for individuals with autism spectrum disorder. Typical goals include improving daily living skills, decreasing harmful behavior, improving social functioning and play skills, improving communication skills and developing skills that result in greater independence.

Approved Clinical Trials
Limited to those clinical trials that are:

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

Authorization see Prior Authorization.

Autism Service Provider means a behavior analyst licensed by the Oregon Behavior Analysis Regulatory Board (BARB), an assistant behavior analysis licensed by BARB and practicing under the supervision of a behavior analyst, and interventionist registered by BARB and practicing under the supervision of a behavior analyst, or a state-licensed or state-certified healthcare professional providing services for autism spectrum disorder within the scope of his or her professional license. In states that do not license autism service providers, certification or registration with the Behavior Analysis Certification Board may be accepted instead.

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

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

Behavioral Health Crisis means a disruption in a person's mental or emotional stability or functioning resulting in an urgent need for immediate outpatient treatment in an emergency department or admission or a hospital to prevent a serious deterioration in the person's mental or physical health.

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

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

Claim Determination Period means a plan year or portion thereof.

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

Condition means a medical condition.

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

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

Covered Service is a service or supply that is specifically described as a benefit in this handbook.

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

Dental Accident means an accidental Injury to natural teeth (see section 8.7.8 for explanation of coverage).

Dental Care means services or supplies provided to prevent, diagnose, or treat diseases of the teeth and supporting tissues or structures, including services or supplies to restore the ability to chew and to repair defects that have developed because of tooth loss. All expenses related to installation of dental implant are considered only under the dental plan (see section 8.7.8 for benefits available following a dental accident.)

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

Domestic Partner refers to a state registered domestic partner or a not state registered domestic partner as follows:

a. **State Registered Domestic Partner** means 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 the subscriber that meets the criteria in the Plan's affidavit of domestic partnership.

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 13.1.1 or 13.1.2

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

Emergency Medical Screening Examination means the medical history, examination (which may include behavioral health assessment), related tests and medical determinations required to confirm the nature and extent of an emergency medical condition.

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

Enroll means to become covered for benefits under the Plan (that is, when coverage becomes effective) without regard to when the person may have completed enrollment. For this purpose, a person who has health coverage is enrolled in the Plan regardless of whether the person elects coverage, the person is a dependent who becomes covered as a result of an election by a subscriber, or the person becomes covered without an election. Please see Section 14 for the enrollment process.

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 and supplies that meet one of the following:

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

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

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

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

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

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

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

Implant means a material inserted or grafted into tissue.

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

In-Network refers to providers such as hospitals, professional providers, chemical dependency treatment programs and facilities that are contracted with Moda Health to provide care to members covered under the Plan.

Intensive Outpatient means mental health or chemical dependency services more intensive than routine outpatient and less intensive than a partial hospital program. Mental health intensive outpatient is 3 or more hours per week of direct treatment. Chemical dependency intensive outpatient is 9-19 hours per week for adults or 6-19 hours per week for adolescents.

Maximum Plan Allowance (MPA) is the maximum amount that the Plan will reimburse providers for medical benefits. 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 using an out-of-network provider, any amount above the MPA may be the member's responsibility except as stated in section 3.1.2.

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

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

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

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

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

Medically necessary care does not include custodial care.

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

More information about medical necessity can be found in General Exclusions (Section 9).

Member means a subscriber or dependent of a subscriber who is enrolled for coverage under the terms of the Plan.

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

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

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

Moda Health refers to Moda Health Plan, Inc. Moda Health is the claims administrator of the Plan. References to Moda Health as paying medical claims or issuing medical benefits mean that Moda Health processes a claim and the Group reimburses Moda Health any benefit issued.

Network means a group of providers who contract to provide healthcare to members at negotiated rates. Such groups are called Preferred Provider Organizations (PPOs), and provide in-network services in their specific service areas. Covered medical expenses will be paid at a higher rate when an in-network provider is used (see section 4.1).

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

Out-of-Pocket Maximum means the maximum amount a member pays out-of-pocket every plan year, including the deductible, coinsurance and copays. If a member reaches the out-of-pocket maximum in a plan year, the Plan will pay 100% of eligible expenses for the remainder of the year.

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

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

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

Plan Sponsor means 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.

Prior Authorization or **Prior Authorized** refers to obtaining approval by Moda Health before the date of a medical service. A complete list of services and supplies that require prior authorization is available on myModa or by contacting Moda Health Customer Service. Failure to obtain required authorization may result in denial of benefits or a penalty (see Section 6 for medical authorization and section 8.10.9 for prescription medication authorization).

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

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

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

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

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

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

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

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 a member does not obtain prior authorization for inpatient, residential (including intense 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, the member should ask the provider to contact Moda Health for prior authorization.

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

Moda Health must receive a completed prior authorization form. Moda Health 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 the member get a second opinion. Moda Health may also specify that the member receive care on an outpatient basis only. The hospital, professional provider and member are notified of the outcome of the authorization process by letter.

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

The following 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 requiring prior authorization may be found on the Moda Health website. This list is updated periodically, and members should ask their provider to check to see if a service or supply requires authorization. A member may obtain authorization information by contacting Moda Health Customer Service. For mental health or chemical dependency 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. Moda Health will authorize medically necessary lengths of stay based upon

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

Authorization must be obtained by calling Moda Health 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 the member's behalf. Members using an out-of-network provider are responsible for ensuring that their provider contacts Moda Health for prior authorization. ***Services not authorized in advance will be denied.*** 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 ***the full financial responsibility of the member*****.**

SECTION 7. COST CONTAINMENT

7.1 SECOND OPINION

Moda Health may recommend an independent consultation to confirm that non-emergency treatment is medically necessary. The Plan pays the full cost of the mandatory second opinion and the deductible is waived. If a member chooses to obtain a second opinion that has not been requested by Moda Health, Plan coverage for that expense would be subject to the deductible and payable at the applicable coinsurance.

7.2 EXTRA-CONTRACTUAL SERVICES

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

After case management evaluation and analysis by Moda Health, 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 agreed upon by a member and his or her professional provider and the Group. Any party can provide notification in writing and terminate such services.

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

SECTION 8. BENEFIT DESCRIPTION

The Plan covers medical services and supplies listed when medically necessary for diagnosis and/or treatment of a medical condition, as well as certain preventive services. The details of the different types of benefits and the conditions, limitations and exclusions are described in the sections that follow. An explanation of important terms is found in Section 5. Prescription medications and vision care are covered by separate plans (see sections 8.10 and 8.11).

Payment of covered medical expenses is always limited to the maximum plan allowance. Expenses are subject to the deductible unless specifically listed as not subject to deductible or listed as covered at no cost sharing. Some benefits have day or dollar limits, which are noted in the Details column in the Schedule of Benefits (see section 4.1).

Many medical services and some supplies require prior authorization. A complete list is available on myModa or by contacting Moda Health Customer Service. **Failure to obtain required prior authorizations may result in denial of benefits, penalty or payment at the out-of-network benefit level** (see Section 6)**.**

8.1 WHEN BENEFITS ARE AVAILABLE

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

a. Is eligible to be covered according to the eligibility provisions of the Plan
b. Has applied for coverage and has been accepted
c. Has paid his or her premiums for the current month on a timely basis (example: COBRA or retiree premiums)

When a member is a hospital inpatient on the day coverage ends, the Plan will continue to pay claims for covered services for that hospitalization until the member is discharged from the hospital or until benefits have been exhausted, whichever comes first.

Benefits are only payable after the service or supply has been provided.

8.2 AMBULANCE TRANSPORTATION

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

Certified air ambulance transportation is covered when medically necessary. The maximum benefit for air ambulance transportation is limited to the amount the Plan would have paid for a ground ambulance. Out-of-network providers may bill members for charges in excess of the maximum plan allowance.

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

8.3 EMERGENCY & URGENT CARE

Care received outside of the United States is only covered for an urgent care or emergency medical condition. Emergency services will be reimbursed at the in-network benefit level. Members will need to pay for these services upfront and submit a claim to Moda Health for reimbursement (as described in section 10.1.6).

8.3.1 Emergency Room Care ($100 Copay)

Members are covered for treatment of emergency medical conditions (as defined in Section 5) worldwide. A member who believes he or she has a medical emergency should call 9-1-1 or seek care from the nearest appropriate provider.

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

All claims for emergency services (as defined in Section 5) will be paid at the in-network benefit level. At an out-of-network emergency room, providers may bill members for charges in excess of the maximum plan allowance. Using an in-network emergency room does not guarantee that all providers working in the emergency room and/or hospital are in-network providers (see section 8.3.1 for more information).

If a covered hospitalization immediately follows emergency services, the emergency room facility copayment will be waived. All other applicable cost sharing remains in effect. 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 required for emergency medical screening exams or treatment to stabilize an emergency medical condition, whether in-network or out-of-network.

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

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

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

8.3.2 Urgent Care

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

8.4 HOSPICE CARE

8.4.1 Definitions

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

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

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

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

8.4.2 Hospice Home Care

The Plan will pay 100% of covered charges for hospice home care visits by any of the following:

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

A visit must be for intermittent medically necessary or palliative care. Custodial care is not covered.

8.4.3 Hospice Inpatient Care

The Plan will pay 100% of covered charges for short-term hospice inpatient services and supplies during the period of covered hospice care.

8.4.4 Respite Care

The Plan will pay 100% of covered charges for respite care (as defined in Section 5) provided to a member who requires continuous assistance when arranged by the attending professional provider and prior authorized. Benefits are limited to 120 hours of respite care in a 3 month period for services provided in the most appropriate setting.

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

8.4.5 Exclusions

In addition to exclusions listed in Section 9, the following are not covered:

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

8.5 Hospital & Residential Facility Care

All hospital and residential facility care must be medically necessary in order to be covered.

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

Hospitalization must be directed by a physician and must be medically necessary for acute care and treatment of a medical condition.

All inpatient and residential stays require prior authorization. See Section 6 for additional information.

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

If benefits under the Plan change while a member is in the hospital, covered expenses will be based on the benefit level in effect when the stay began. The same rule applies to stays in other kinds of medical facilities.

8.5.1 Chemical Dependency Detoxification Program

All-inclusive daily charge for room and treatment services by a state-licensed treatment program.

8.5.2 Diagnostic Procedures

The Plan covers diagnostic services, including x-rays and laboratory tests, psychological and neuropsychological testing, and other diagnostic procedures related to treatment of a medical or mental health condition.

The Plan covers all standard imaging procedures related to treatment of a medical condition. Some advanced imaging services require prior authorization (see 0), including radiology (such as MR procedures (including MRI and MRA), CT, PET and nuclear medicine) and cardiac imaging.

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

8.5.3 Hospital Benefits

Covered expenses for hospital care consist of the following:

a. **Hospital room**, the actual daily charge
b. **Isolation care**, when it is medically necessary to protect a member from contracting the illness of another person or to protect other patients from contracting the illness of a member
c. **Intensive care unit.** Using generally recognized industry standards as a guide, the Plan reserves the right to decide whether a unit in a particular hospital qualifies as an intensive care unit
d. **Facility charges** for surgery performed in a hospital outpatient department
e. **Other hospital services and supplies** (including prescription medications dispensed while the member is hospitalized) that are medically necessary for treatment and are ordinarily furnished by a hospital. These include, but are not limited to, operating and recovery room, and traction equipment
f. **Take-home prescription medications.** Limited to a **3-day supply, issued by the hospital,** at the same benefit level as for hospitalization. (Refer to 8.10 for the retail and/or mail order prescription medication coverage).

8.5.4 Hospital Visits

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

8.5.5 Pre-admission Testing

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

8.5.6 Rehabilitative & Habilitative Care

Rehabilitative services are covered when they are a medically necessary part of a physician's formal written program to improve and restore lost function following an illness or injury.

Covered expenses include rehabilitative care for inpatient services delivered in a hospital or other inpatient facility that specializes in such care. These benefits will continue only as long as the member requires the full rehabilitative team approach and services can only be provided on an inpatient basis. Habilitative services are covered only for medically necessary treatment of a mental health condition.

8.5.7 Residential Mental Health & Chemical Dependency Treatment Programs

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

8.5.8 Skilled Nursing Facility Care

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

Care at a skilled nursing facility require prior authorization. Covered expenses are limited to 100 days per year at the daily service rate, up to the amount the Plan would pay if the member were in a semi-private hospital room. The member's attending physician must provide proof of medical necessity, that is acceptable to Moda Health, showing that the member would require hospitalization if care in a skilled nursing facility were not possible.

Care beyond 100 days may be authorized by Moda Health when the attending physician reports that additional skilled nursing care is necessary for treatment of that illness of injury.

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

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

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

8.6 OUTPATIENT SERVICES

Many outpatient services require prior authorization. A complete list is available on myModa or by contacting Moda Health Customer Service. **Failure to obtain required prior authorization may result in denial of benefits, penalty or payment at the out-of-network benefit level** (see Section 6)**.**

Certain diagnostic and therapeutic procedures can be performed without an inpatient admission or overnight stay in a hospital. Prior authorization must be obtained for any inpatient admission or overnight stay for a service that is commonly performed on an outpatient basis. Any covered benefit will be based on the cost of the most appropriate setting for the procedure. All services must be medically necessary.

8.6.1 Cardiac Rehabilitation

Coverage for cardiac rehabilitation therapy is limited to medically necessary care following a diagnosis of cardiac arrhythmia and unstable angina. If care is no longer restoring or improving a lost function but for maintaining a level of function or restoration, it is considered maintenance care and is not eligible for coverage.

8.6.2 Chemical Dependency Services

Services for assessment and treatment of chemical dependency in an outpatient treatment program that meets the definitions in the Plan (see Section 5) are covered, subject to medical necessity.

8.6.3 Clinical Trial

Usual care costs for the care of a member who is enrolled in or participating in an approved clinical trial (as defined in Section 5) are covered. Usual care costs mean medically necessary conventional care, items or services covered by the Plan if typically provided absent a clinical trial. Such costs will be subject to the same cost sharing that would apply if provided in the absence of a clinical trial.

The Plan does not cover items or services:

a. That are not covered by the Plan if provided outside of the clinical trial, including the drug, device or service being tested
b. Required solely for the provision or clinically appropriate monitoring of the drug device or service being tested in the clinical trial

c. Provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the member
d. Customarily provided by a clinical trial sponsor free of charge to any person participating in the clinical trial

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

8.6.4 Diagnostic Procedures

The Plan covers diagnostic services, including x-rays and laboratory tests, psychological and neuropsychological testing, and other diagnostic procedures related to treatment of a medical or mental health condition.

The Plan covers all standard imaging procedures related to treatment of a medical condition.

Some advanced imaging services require prior authorization including the following:

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

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

8.6.5 Infusion Therapy

The Plan covers infusion therapy services and supplies when prior authorized and ordered by a professional provider as a part of an infusion therapy regimen. Members should contact Moda Health Customer Service before receiving such care.

Infusion therapy benefits are limited to the following:

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

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

a. solutions, medications, and pharmaceutical additives
b. pharmacy compounding and dispensing services
c. durable medical equipment (DME) for the infusion therapy
d. ancillary medical supplies
e. nursing services associated with:
    i. patient and/or alternative care giver training

ii. visits necessary to monitor Intravenous therapy regimen
iii. emergency services
iv. administration of therapy

f. collection, analysis, and reporting of the results of laboratory testing services required to monitor response to therapy

8.6.6 Kidney Dialysis

Covered expenses include:

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

8.6.7 Outpatient Surgery - Outpatient Facility

The Plan covers operating rooms and recovery rooms, surgical supplies and other services ordinarily provided by a hospital or surgical center. Outpatient surgery requires prior authorization (see Section 6).

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

8.6.8 Rehabilitation & Habilitation– Outpatient Physical, Occupational and/or Speech Therapies

Up to 60 sessions are covered each plan year for rehabilitative services provided by a professional provider to a member who is not confined in a hospital. Medically necessary outpatient services for mental health and chemical dependency are not subject to the 60 sessions limit. A session is one visit. **No more than one session of each type of therapy (physical, occupational, or speech) is covered in one day.** Medical necessity review is required after 30 sessions.

Rehabilitative services are physical, occupational or speech therapies provided by a licensed physical, occupational or speech therapist, physician, chiropractor or other professional provider licensed to provide such services; They are necessary to restore or improve lost function caused by a medical condition. Outpatient rehabilitative services are short term in nature with the expectation that the member's condition will improve in a reasonable and generally predictable period of time.

If care is no longer restoring or improving lost function, but maintains a level of function or restoration, that is considered maintenance care and is not eligible for coverage.

Habilitative services are used to establish skills that were never developed due to a medical condition. Habilitative physical, occupational or speech therapy is covered only when medically necessary for treatment of a mental health condition.

Excluded services include:

a. Therapy performed to maintain a current level of functioning without documentation of improvement is considered maintenance therapy
b. Maintenance programs that prevent regression of a condition or function

c. Recreational or educational therapy, educational testing or training
d. Non-medical self-help or training
e. Equine therapy

8.6.9 Therapeutic Radiology

Covered expenses include:

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

8.7 Professional Provider Services

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

8.7.1 Acupuncture Care

Covered acupuncture services are short-term in nature with the expectation that the member's condition will improve in a reasonable and generally predictable period of time. The Plan covers the services provided within the scope of the professional provider's license. Benefits will be paid at the standard plan coinsurance level. Coverage is limited to 20 visits per plan year. Additional acupuncture treatment may be covered by the Plan upon review by Moda Health for medical necessity.

Other services, such as office visits or lab and diagnostic services are not covered under this benefit. They are paid under the Plan's standard benefit for the type of service provided.

8.7.2 Alternative Care (Chiropractic Care, Naturopathic Substances and Massage Therapy)

Alternative care means spinal manipulation, naturopathic substances and massage therapy. To be covered, alternative care must be within the scope of the professional provider's license. It also must not be specifically excluded under the Plan.

The Plan will waive deductible and pay 50% of covered expenses for alternative care. Massage therapy MUST be ordered by a licensed physician or a professional provider within his or her scope of license to be eligible for coverage. Benefit payments will be limited to a $350 maximum per member per plan year. Reimbursement and visit limits for other services, such as office visits, lab and diagnostic x-rays, and physical therapy services are under the Plan's standard benefit for the type of service provided.

This specific benefit does not require the use of in-network providers.

8.7.3 Applied Behavior Analysis

Medically necessary applied behavior analysis for autism spectrum disorder (including the symptoms formerly designated as pervasive developmental disorder) and the management of care provided in the member's home, a licensed health care facility or other setting as approved by Moda Health is covered. Prior authorization and submission of an individualized treatment plan are required.

Coverage for applied behavior analysis does not include:

a. Services provided by a family or household member

b. Custodial or respite care, equine assisted therapy, creative arts therapy, wilderness or adventure camps, music therapy, neurofeedback, chelation or hyperbaric chamber
c. Services provided under an individual education plan in accordance with the Individuals with Disabilities Education Act (20 USC 1400 et seq)
d. Services provided by the Department of Human Services or Oregon Health Authority, other than employee benefit plans offered by the Department and the Authority

8.7.4 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.

8.7.5 Cochlear Implants

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

8.7.6 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 <u>all</u> 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

8.7.7 Contraception

All FDA approved contraceptive methods and counseling are covered. When delivered by an in-network provider and utilizing the most cost effective option (e.g., generic instead of brand name), contraception will be covered with no cost sharing. If there is not an in-network provider available within a reasonable distance to provide the cost-effective contraceptive services timely, services will be authorized at no cost sharing with an out-of-network provider. Over the counter contraceptives are covered under the Pharmacy benefit (8.10).

8.7.8 Dental Care Following an Accident

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

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

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

8.7.9 Diabetes Services

Insulin, meters, pumps and other diabetic testing supplies are covered under the pharmacy prescription benefit (section 8.10.4) when purchased 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. Meters, pumps and other supplies may also be covered under the DME benefit (section 8.8.3) when billed by a doctor.

Covered medical services for diabetes screening and management include:

a. Screening for pre-diabetes diagnosis
b. HbA1c lab test
c. Checking for kidney disease
d. Annual dilated eye exam or retinal imaging, including one performed by an optometrist or ophthalmologist.
e. Diabetes self-management programs covered at no cost sharing:
    i. One diabetes program of assessment and training for pre-diabetes or after diagnosis.
    ii. Up to 3 hours of assessment and training following a material change of condition, medication or treatment, when provided by a program or provider with a demonstrated experience in diabetes

f. Dietary or nutritional therapy
g. Routine foot care when medically necessary

Telemedicine or telecare (section 8.7.26) in connection with covered treatment of diabetes can be delivered via audio, video conferencing, Voice over Internet Protocol, or transmission of telemetry. One of the participants must be a representative of an academic health center.

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

8.7.10 Gender Reassignment (Transgender Surgery)

Expenses for gender reassignment are covered when the following conditions are met:

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 procedures include:

a. Single stage or multiple stage reconstruction of the genitalia
b. Reconstruction of breast tissue to achieve the appearance of the new gender
c. Mental health
d. Hormone therapy (including puberty suppression therapy for adolescents)

e. Hair removal for surgical reconstruction (i.e., genital hair removal)
f. Facial hair removal
g. Voice therapy/voice modification (or voice and communication training)

Covered services are subject to standard plan cost sharing (in-network and out-of-network coverage).

The following services are excluded from coverage by the Plan as part of the treatment of gender dysphoria:

a. Treatment of acne as a complication of hormone therapy
b. Treatment of infertility as a complication of gender identity treatment
c. Reversal of gender identity treatments and surgery
d. hair transplantation
e. Liposuction
f. Thyroid cartilage reduction
g. Abdominoplasty
h. Facial reconstruction not related to accident or Injury
i. Makeup evaluation
j. Legal expenses related to name change
k. Procedures and treatments that are not hormone therapy, psychotherapy or surgery for the reconstruction of genitalia
l. Travel or lodging expenses

8.7.11 Hearing Examinations and Testing & Hearing Aids – Benefit For Subscribers, Spouses & Domestic Partners 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. 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 aids, members can call Hearing Services Customer Service to choose an in-network audiologist and arrange for a hearing exam. The audiologist will help members with their choices of hearing aids available to Plan members by the hearing services network through an in-network hearing instrument provider. Members can also use other in-network and out-of-network providers.

8.7.12 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 for members under age 4 and once per plan year for members age 4 to 26 at 85%.

8.7.13 Hearing Services for Members – State of Oregon Mandated Benefit

The following items are covered once every 3 plan years for members under age 26. The Plan will pay at the in-network benefit level after the deductible.

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

In addition:

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

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

Covered expenses are subject to the deductible. Routine earing exams are not covered in this section.

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

8.7.14 Inborn Errors of Metabolism

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

8.7.15 Infertility Diagnosis

The Plan covers diagnosis of infertility including office visits, lab tests, imaging services and outpatient procedures up to a lifetime maximum of $10,000 for each member.

8.7.16 Maxillofacial Prosthetic Services

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

a. Controlling or eliminating infection
b. Controlling or eliminating pain
c. Restoring facial configuration or functions such as speech, swallowing or chewing excluding cosmetic procedures to improve on the normal range of conditions

8.7.17 Mental Health

The Plan covers medically necessary outpatient services including behavioral health case management and peer support, other than diagnostic testing, by a mental health provider. Intensive outpatient treatment requires prior authorization. See Section 5 for definitions. See section 8.6.4 for coverage of diagnostic services.

8.7.18 Newborn Nursery Care and Visits

Routine nursery care of a newborn is covered while the mother is confined to the hospital and receiving maternity benefits under the Plan. The deductible is waived for routine nursery care.

One in-nursery well-newborn infant preventive health exam is covered at no cost sharing when performed in-network. Additional visits are covered at the hospital visit benefit level with deductible waived.

8.7.19 Nutritional Therapy

Nutritional therapy for eating disorders is covered when medically necessary. Authorization is required after the first 5 visits. Preventive nutritional therapy that may be required under the Affordable Care Act is covered under the preventive care benefit. Also see diabetes services (section 8.7.9) and inborn errors of metabolism (section 8.7.14).

8.7.20 Office or Home Visits

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

8.7.21 Podiatry Services

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

8.7.22 Preventive Services

As required under the Affordable Care Act (ACA), certain services will be covered at no cost to the member when performed by an in-network provider. (See section 4.1 for benefit level when services are provided out-of-network. Some services are not covered out-of-network.) The Plan will use reasonable medical management techniques to determine coverage limitations where permitted by the ACA. This means that some alternatives in the services below may be subject to member cost sharing:

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

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

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

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

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

    i. 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.

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

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

Routine diagnostic x-ray and lab work related to a preventive health exam that is not required by the ACA is subject to the cost sharing (see 4.14.1).

b. Immunizations. Routine immunizations for members of all ages, limited to those recommended by the ACIP. Some common immunizations include:

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

Immunizations for the sole purpose of travel or to prevent illness that may be caused by a work environment are not covered.

c. Pediatric Screenings. At the frequency and age recommended by HRSA or USPSTF, including:

i. Screening for hearing loss in newborn infants.
ii. Routine Vision Screening to detect amblyopia, strabismus and defects in visual acuity in children age 3 to 5
iii. Developmental and behavioral health screenings

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

Breast exams are limited to women 18 years of age and older. Mammograms are limited to one between the ages of 35 and 39, and one per plan year age 40 and older. Pap tests and breast exams, and mammograms for the purpose of screening or diagnosis in symptomatic or designated high risk women, are also covered when deemed necessary by a professional provider. These services are covered under the office visit, x-ray or lab test benefit level if not performed within the Plan's age and frequency limits for preventive screening.

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

f. Colorectal cancer screening. The following services, including related charges, for members age 50 and over:

i. One flexible sigmoidoscopy and pre-surgical exam or consultation every 5 years
ii. One colonoscopy, including polyp removal, and pre-surgical exam or consultation every 10 plan years
iii. One double contrast barium enema every 5 years
iv. One fecal DNA test every 3 years
v. One fecal occult blood test every plan year

These screening timelines align with the USPSTF recommendations for individuals not at high risk for colorectal cancer. Screening procedures performed more frequently must be determined medically necessary.

Anesthesia that is medically necessary to perform the above preventive services is covered under the preventive benefit. If the anesthesia is determined not medically necessary, it is not covered.

Colorectal cancer screening is covered at the medical benefit level if it is not performed for preventive purposes (e.g., screening is for diagnostic reasons or to check symptoms), except that if the member has a positive result on a fecal occult blood test covered under the preventive benefit, a follow-up colonoscopy will be covered under the preventive benefit. For members who are at high risk for colorectal cancer with a family medical history of colorectal cancer, a prior occurrence of cancer or precursor neoplastic polyps, a prior occurrence of a chronic digestive disease condition such as inflammatory bowel disease, Crohn's disease or ulcerative colitis, or other predisposing factors, colorectal cancer screening exams and laboratory tests are covered as recommended by the treating professional provider and are paid at the medical benefit level if outside the preventive screening age and frequency limits.

Other preventive services include breastfeeding support (section 8.8.2), contraception (section 8.7.7) and tobacco cessation (section 8.7.29).

8.7.23 Reconstructive Surgery Following A Mastectomy

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

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

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

8.7.24 Surgery, Cosmetic & Reconstructive

Cosmetic surgery is surgery that improves or changes appearance without restoring impaired body function.

Reconstructive surgery is surgery performed on abnormal structures of the body, caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease. It is usually performed to improve function, but may also be done to approximate a normal appearance.

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

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

Nasal rhinoplasty is not covered when it is determined to be cosmetic surgery by Moda Health's medical director.

Surgery for breast augmentation, achieving breast symmetry, and replacing breast Implants (prosthetics) to accomplish an alteration in breast contour or size are not covered except as provided in section 8.7.23 and 8.7.10.

8.7.25 Surgery, In General

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

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

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

8.7.26 Telemedicine

Covered medical services, when generally accepted healthcare practices and standards determine they can be safely and effectively provided using synchronous 2-way interactive video conferencing, are covered when provided by a provider using such conferencing. The application and technology used must meet all state and federal standards for privacy and security of protected health information. Benefit are subject to the standard cost sharing for the covered medical services. Telemedicine and telemedical care for excluded services are not covered (see section 9.52).

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

8.7.27 Temporomandibular Joint Syndrome (TMJ)

All TMJ related services, including but not limited to diagnostic, surgical procedures and splints, require prior authorization, and are covered only when medically necessary as established by a medical history of arthritic degeneration documented in a physician's medical record, or in cases

involving severe acute trauma. 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. Members who are also enrolled in the Delta Dental Plan provided by the Group have limited coverage for nightguards under the Delta Dental Plan.

8.7.28 Therapeutic Injections

Administrative services for therapeutic injections, such as allergy shots, are covered when given in a professional provider's office. When comparable results can be obtained safely with self-administered medications at home, the administrative services for therapeutic injections by the provider are not covered. Vitamin and mineral injections are not covered unless medically necessary for treatment of a specific medical condition. Additional information in section 8.9.1.

8.7.29 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. Recommended medications are covered under a separate plan (see section 8.10).

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

8.8 OTHER SERVICES

8.8.1 Biofeedback Therapy

Covered expenses for biofeedback therapy services are limited to treatment of tension or migraine headaches. Covered visits are subject to 10 visits per lifetime. Expenses for biofeedback therapy for other diagnostic conditions or in excess of the 10 lifetime visits are not covered.

8.8.2 Breastfeeding Support

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

8.8.3 Durable Medical Equipment (DME), Supplies & Appliances

Equipment and related supplies that help members manage a medical condition are covered. If members receive these services from out-of-network providers, the service will be reimbursed at the out-of-network benefit level. DME is typically for home use and is designed to withstand repeated use.

Some examples of DME, supplies and appliances are:

a. CPAP for sleep apnea
b. Meters, pumps and diabetes supplies (see section 8.7.9)
c. Glasses or contact lenses only for the diagnoses of aphakia or keratoconus
d. Hospital beds and accessories
e. Intraocular lenses within 90 days following cataract surgery
f. Light boxes or light wands only when treatment is not available at a provider’s office

g. Orthotics, orthopedic braces, orthopedic shoes to restore or maintain the ability to complete activities of daily living or essential job-related activities. If needed correction or support is accomplished by modifying a mass-produced shoe, then the covered expense is limited to the cost of the modification.
h. Oxygen and oxygen supplies
i. Prosthetics: 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 Moda Health that a new prosthetic device is medically necessary because of changing fit or poor function.
j. Shoe Insert Orthotics: The Plan covers specially made shoe insert orthotics. The Plan will cover one pair every 24-months. For members under age 21, the Plan may allow more frequently upon review.
k. Wig: A wig is covered once per plan year when necessary for hair loss resulting from chemotherapy or radiation therapy.
l. Wheelchair or scooter (including maintenance expenses)
m. Ice therapy equipment and accessories after surgery

The Plan covers the rental charge (not to exceed the purchase price) for DME. Members can work with their providers to order their prescribed DME. Contact Moda Health Customer Service for help finding a DME provider.

All supplies, appliances and DME must be medically necessary. Some require prior authorization (see Section 6). Replacement or repair is only covered if the appliance, prosthetic device, equipment or DME was not abused not used beyond its specifications and not used in a manner to void applicable warranties. Upon request, members must authorize any supplier furnishing DME to provide information related to the equipment order and any other records Moda Health requires to approve a claim payment.

Exclusions
In addition to the exclusions listed in Section 9, the Plan will not cover the following appliances and equipment, even if they relate to a condition that is otherwise covered by the Plan:

a. Those used primarily for comfort, convenience, or cosmetic purposes
b. Toupees
c. Those used for education or environmental control (examples of supportive environmental materials can be found in Section 9)
d. Therapeutic devices, except for transcutaneous nerve stimulators
e. Incontinence supplies
f. Dental appliances and braces
g. Supporting devices such as corsets, compression or therapeutic stockings except when such stockings are medically necessary
h. Testicular prostheses

Neither Moda Health nor the Plan 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.

8.8.4 Home Healthcare and Skilled Nursing Care
Home healthcare and skilled nursing care services and supplies are covered for a member who is homebound when ordered by a professional provider and provided by a home healthcare agency or a covered provider. “Homebound” means that the member’s condition creates a general

inability to leave home. If the member does leave home, the absences must be infrequent, of short duration, and mainly for receiving medical treatment. A home healthcare agency is a licensed public or private agency that specializes in providing skilled nursing and other therapeutic services, such as physical therapy, in the member's home.

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

a. Registered or licensed practical nurse
b. Physical, occupational, speech, or respiratory therapist

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

This benefit does not include home healthcare, home care services, and supplies provided as part of a hospice treatment plan. These are covered under section 8.4.

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 8.6.8).

A member may receive skilled nursing care from a nurse who ordinarily resides in the member's home or who is related to the member by blood or marriage if documentation is provided to Moda Health 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. Members should contact Moda Health Customer Service before receiving such care.

8.8.5 Maternity Care

Pregnancy care, childbirth and related conditions are covered under the Plan on the same basis as an illness. Services must be rendered by a professional provider. Professional providers do not include midwives unless they are licensed and certified. The Plan covers facility charges for maternity care when rendered at a covered facility, including a birthing center.

Elective abortions are covered at no cost sharing when performed by an in-network provider. Home birth expenses are not covered other than the fees billed by the professional provider. Additional information regarding home birth exclusions is in section 9.18. Supportive services, such as physical, emotional and informational support to the mother before, during and after birth and during the postpartum period, are not covered expenses.

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

8.8.6 Nonprescription Enteral Formula For Home Use

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

8.8.7 Transplants

The Plan covers medically necessary and appropriate transplant procedures that conform to accepted medical practice and are not experimental or investigational. (More information regarding experimental or investigational procedures in Section 5).

a. Definitions

Center of Excellence means a facility and/or team of professional providers with which Moda Health has contracted and arranged to provide facility transplant services. Centers of Excellence have rigorous standards based on best practices, and have exceptional skills and expertise in managing patients with a specific condition.

Complications resulting from a transplant means all related medical and surgical treatments except the transplantation of hematopoietic cells or solid organ(s).

Donor costs means the covered expense of removing the tissue from the donor's body and preserving or transporting it to the site where the transplant is performed as well as any other necessary charges directly related to locating and procuring the organ.

Transplant means a procedure or series of procedures by which:

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

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

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

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

c. Covered Benefits for transplants are limited as follows:

i. The Plan will pay 85% of the contracted amount for facility fees when a transplant is performed at a Center of Excellence.
ii. Transplant procedures must be performed at a Center of Excellence. If a Center of Excellence cannot provide the necessary type of transplant, Moda Health will prior authorize services at an alternative transplant facility.
iii. Donor costs covered as follows:

A. If the recipient or self-donor is enrolled in the Plan, donor costs related to a covered transplant, including expenses for an enrolled donor resulting from complications and unforeseen effects of the donation, are covered

B. If the donor is enrolled in the Plan and the recipient is not, the Plan will not pay any benefits toward donor costs.
C. If the donor is not enrolled in the Plan, expenses that result from complications and unforeseen effects of the donation are not covered

iv. Professional provider transplant services are paid according to the benefits for professional providers;
v. Immunosuppressive medications provided during a hospital stay are paid as a medical supply. Outpatient oral and self-injectable prescription medications for transplant-related services are subject to the rules, provision, and benefit coverage available under the Pharmacy Prescription Expense Benefit (see section 8.10).

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

d. Exclusions
In addition to the exclusions listed in Section 9, 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.

8.9 MEDICATIONS

8.9.1 Medication Administered by Professional Provider, Infusion Center, or Home Infusion

A medication that is required to be administered in a professional provider's office, infusion center or home infusion is generally covered at the same benefit level as supplies and appliances (see section 4.1). Coverage under the Pharmacy Prescription Benefit is in section 8.10.

8.9.2 Anticancer Medication

Prescribed anticancer medications, including oral, intravenous (IV) or injected medications, are covered. Most anticancer medications may require prior authorization by Moda Health for medical expenses and WellDyneRx for prescription medication expenses and may be subject to specific benefit limitations. More information is available by contacting WellDyneRx Customer Service. See the Pharmacy Prescription Benefit in section 8.10.

8.10 PHARMACY PRESCRIPTION BENEFIT

8.10.1 WellDyneRx Pharmacy Program

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

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 members 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%.

8.10.2 Definitions

Brand Medications. A brand medication is sold under a trademark and protected name. These products are considered exclusive and can only be produced and sold by the manufacturer holding the patent.

Brand Substitution. Brand substitution is a policy on how prescription medications are filled at the pharmacy. Both generic and brand medications are covered. If a member requests, or the treating professional provider prescribes, a brand medication when a generic equivalent is available, the member 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. A formulary is a listing of all prescription medications and their coverage under the pharmacy benefit.

Generic Medications. Generic medications have been found by the Food and Drug Administration (FDA) to be therapeutically equivalent to the brand alternative and are often the most cost effective option.

Generic medications must contain the same active ingredients as their brand counterpart and be identical in strength, dosage form and route of administration. 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. Non-Formulary 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. An over-the-counter medication is a medication that may be purchased without a professional provider's prescription. WellDyneRx follows the federal designation of OTC medications to decide if an OTC medication is covered by the prescription medication plan.

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

Select Tier 1 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 have been identified as favorable from a clinical and cost effective perspective.

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

Value Tier Medications. Value tier medications include commonly prescribed products used to treat chronic medical conditions and preserve health. A list of value tier medications is available by contacting WellDyneRx.

8.10.3 Covered Expenses

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

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

8.10.4 Covered Medication Supply

A covered medication supply includes the following:

a. A prescription medication that is medically necessary for treatment of a medical condition
b. Compounded medications containing at least one covered medication as the main ingredient
c. Insulin, pumps, meters and diabetic supplies including insulin syringes, needles and lancets, glucometers and test strips when accompanied by a valid prescription
d. Prescription contraceptive medications and devices for birth control (section 8.7.7) and Medical Conditions covered under the prescription medication plan. Each contraceptive can be filled by the pharmacy up to a 3-month supply at the initial fill and up to a 12-month supply for subsequent fills. Contact WellDyneRx Customer Service for information on how to obtain a 12-month supply.
e. Select prescribed preventive medications required under the Affordable Care Act
f. Medications for treating tobacco dependence, including prescribed OTC nicotine patches, gum or lozenges, with a valid prescription and from an in-network retail pharmacy available with no cost sharing as required under the Affordable Care Act
g. Certain immunizations and related administration fees are covered with no cost sharing at in-network retail pharmacies (e.g. influenza, pneumonia and shingles vaccines).

Certain prescription medications and/or quantities of prescription medications may require prior authorization (see section 8.10.9). Specialty tier medications must be dispensed through an exclusive specialty pharmacy coordinator. For assistance coordinating prescription refills, contact WellDyneRx Customer Service.

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

8.10.5 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, members are responsible for any amount above the MPA.

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

Members 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.

8.10.7 Specialty Services and Pharmacy benefit (limited to 30 day supply)

The pharmacist and other professional providers will tell a member 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 a member does 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.

8.10.8 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 members of the program when an eligible medication is prescribed. Members 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 a member chooses not to enroll, the 40% copay/coinsurance will apply.

Coupons for eligible specialty medications may only be used by members 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.

8.10.9 Utilization Management

8.10.9.1 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 with respect to evidence based criteria that align with medical literature, best practice clinical guidelines and guidance from the FDA. Requiring prior authorization ensures member safety, promotes proper use of medications and supports cost effective treatment options for members.

8.10.10 Limitations

The following limitations apply:

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 are subject to review and may have additional coverage requirements or limits set by the prescription medication plan. A member or prescriber can request a medical necessity evaluation if a newly approved medication is initially denied during the review period.
c. Medications purchased outside of the United States and its territories are only covered in emergency and urgent care situations
d. Early refill of medications for travel outside of the United States will be reviewed. When allowed, early refill is limited to once every 6 months. Early refill cannot be used to cover a medication supply beyond the end of the plan year.

e. Emergency insulin refills and supplies are limited to the lesser of the smallest available package or a 30-day supply and are covered no more than 3 times per year.
f. Medications with dosing intervals greater than the prescription medication plan's maximum day supply will have an increased copayment to match the day supply.

8.10.11 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 9 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 purchased from non-U.S. mail order or online pharmacies or U.S. mail or online pharmacies acting as agents of non-U.S. pharmacies
c. **Hair Growth Medications**
d. **Immunization Agents for Travel**
e. **Institutional Medications.** To be taken by or administered to a member in whole or in part while the member is a patient in a hospital, sanitarium, rest home, skilled nursing facility, extended care facility, nursing home, or similar institution. These medications could be covered under the medical plan
f. **Medication Administration.** A charge for administration or injection of a medication, except for certain immunizations 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 approved by Oregon's Health Evidence Review Commission) or Pharmacy Therapeutics and Review Committee
l. **Over the Counter (OTC) Medications** and prescription medications for which there is an OTC equivalent or alternative, except for contraceptives and emergency contraceptives, condoms, spermicide or those treating tobacco dependence
m. **Repackaged Medications**
n. **Replacement Medications and/or Supplies**
o. **Untimely Dispensing.** Medications that are dispensed more than one year after the order of a professional provider
p. **Vitamins and Minerals.** The prescription medication plan does not cover over-the-counter (OTC) vitamins and minerals except as required by law
q. **Weight Loss Medications**

8.10.12 Appeal Process For Prescription Medication Benefits

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

Members 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 the member's 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 the member to experience an adverse medical reaction, or experience a lack of therapeutic response, the physician must confirm he/she has completed and submitted 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. Members will be advised in writing of the decision.

8.11 Routine Vision Care Benefit

The Plan provides each member with coverage for the following vision care services through VSP. See section 8.7.9 under the medical benefit for coverage of an annual dilated eye exam for management of diabetes.

8.11.1 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 13.1.

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 8.11.4 and 8.11.5.

8.11.2 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 a member's geographic location can be obtained from the Group or VSP. If this list does not cover the geographic area necessary to seek services, members may call or write to the nearest VSP office to obtain one that does.
b. For members who are eligible for vision plan benefits, VSP will provide benefit authorization directly to the in-network doctor. When contacting an In-network doctor directly, members must identify themselves as VSP members 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 the member's termination of coverage or the termination of the vision care plan. Should members receive services from an in-network doctor without such benefit authorization or obtain services from a provider who is not an In-network doctor, they are responsible for payment in full to the provider.
d. Members 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: Members who are eligible for and obtain plan benefits from an out-of-network provider should pay the provider his/her full fee. Then they will be reimbursed by VSP in accordance with the out-of-network provider reimbursement schedule shown in section 8.11.5, 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 members at the time of termination and permit the in-network doctor to continue to provide members 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.

8.11.3 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 members by the Group under this vision care plan. When a member requests vision services, his or her prior utilization of vision plan benefits will be reviewed by VSP to determine if the member is eligible for new services based upon the Plan's level of coverage. Please refer to sections 8.11.4 and 8.11.5 for a summary of the level of coverage provided by the Group.

8.11.4 Benefits and Coverages

Through its in-network doctors, VSP provides vision plan benefits to members, subject to the limitations, exclusions, and copayment(s) described in the following sections. To obtain vision plan benefits from an in-network doctor, members should contact the in-network doctor of their choice, identify themselves as a VSP member, and schedule an appointment. For members who 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 8.11.5 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 a member's 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 8.11.5, 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 8.11.5.

   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 8.11.5. 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 members 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, members should pay the out-of-network provider his/her full fee. VSP will reimburse members in accordance with the reimbursement schedule shown in section 8.11.5, 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 for members who have acuity or visual field loss that cannot be corrected with regular lenses. If a member falls within this category, he or she 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 8.11.5. 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)	Limitations (Out-of-Network Provider
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.	

8.11.5 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 • 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

8.11.6 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. Members may obtain details regarding frame brand availability from their 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 members select any of the following options, the vision care plan will pay the basic cost of the allowed lenses or frames, and members will be responsible for the options extra cost, unless it is defined as a vision plan benefit in section 8.11.5.

- 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 8.11.5.
- Services/materials not indicated as covered Plan Benefits in sections 8.11.4 and 8.11.5.

8.11.7 Liability in Event of Nonpayment

In the event VSP fails to pay the provider, a member 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.

8.11.8 Complaints and Grievances

If a member ever has a question or problem, his or her first step is to call VSP's Customer Service Department. The Customer Service Department will make every effort to answer the member's question and/or resolve the matter informally. If a matter is not initially resolved to the member's satisfaction, the member 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. Members 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 the member to indicate VSP's expected resolution date. Upon final resolution, the member will be notified of the outcome in writing.

8.11.9 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 the member or his or her 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 a member's claim for benefits is denied by VSP in whole or in part, VSP will notify the member 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, the member 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. The member may state the reasons he or she believes that the claim denial was in error. The member may also provide any pertinent documents to be reviewed. VSP will review the claim and give the member 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. The member or his or her 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 the member within thirty (30) calendar days after receipt of a request for appeal from the member or his or her authorized representative.

If the member disagrees with VSP's determination, he/she 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.

SECTION 9. GENERAL EXCLUSIONS

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

9.1 Benefits Not Stated

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

9.2 Care Outside the United States

Scheduled care or care that is not due to an urgent or emergency medical condition

9.3 Charges Over the Maximum Plan Allowance

Except when required under the Plan's Coordination of Benefits rules (see section 11.1).

9.4 Comfort and First-Aid Supplies

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

9.5 Cosmetic Procedures

Any procedure or medication requested for the purpose of improving or changing appearance without restoring impaired body function, including rhinoplasty, breast augmentation, lipectomy, liposuction, and hair removal (including electrolysis and laser). Exceptions are provided for reconstructive surgery if medically necessary and not specifically excluded (see sections 8.7.24, 8.7.23 and 8.7.10).

9.6 Court-Ordered Sex Offender Treatment

9.7 Custodial Care

Routine care and hospitalization that helps a member with activities of daily living, such as bathing, dressing and getting in and out of bed. Custodial care includes care that is primarily for the purpose of keeping a member safe, or for holding a member awaiting admission to the appropriate level of care.

9.8 Dental Examinations and Treatment or Orthodontia

Except as specifically provided for in section 8.7.24 or if medically necessary to restore function due to craniofacial anomaly. *(Members who have elected to enroll in the Delta Dental Plan should refer to that plan for dental and orthodontic coverage.)*

9.9 Educational Supplies

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

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

9.11 Experimental or Investigational Procedures
Including expenses incidental to or incurred as a direct consequence of such procedures (see definition of experimental/investigational in Section 5).

9.12 Faith Healing
Even when provided by an In-Network Provider is not covered.

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

9.14 Financial Counseling Services

9.15 Food Services
Meals on Wheels and similar programs.

9.16 Guest Meals in a Hospital or Skilled Nursing Facility

9.17 Hearing Aids
Including:

a. Replacement of a hearing aid, for any reason, within the required time period
b. A hearing aid exceeding the specifications prescribed for correction of hearing loss
c. Expenses incurred after coverage ends, unless the hearing aid is ordered before coverage terminated and it is received within 90 days of the coverage end date

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

9.19 Homemaker or Housekeeping Services

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

9.21 Immunizations
Immunizations for the sole purpose of travel or to prevent illness that may be caused by a work environment are not covered.

9.22 Infertility
All services and supplies for treatment of infertility.

9.23 Inmates
Services and supplies a member receives while in the custody of any state or federal law enforcement authorities or while in jail or prison, except when pending disposition of charges or

in detention facility pending adjudication by juvenile court. Benefits paid under this exception may be limited to 115% of the Medicare allowable amount.

9.24 Legal Counseling

9.25 Mental Examination and Psychological Testing and Evaluations
For the purpose of adjudication of legal rights, administrative awards or benefits, corrections or social service placement, employment, or any use except as a diagnostic tool for the treatment of mental health condition or as specifically provided in section 8.7.4.

9.26 Missed Appointments
Charges by a professional provider or any other provider for scheduled appointments that were missed by a member.

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

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

9.29 Nutritional Therapy
Except as provided for in section 8.7.19.

9.30 Obesity or Weight Reduction
Even if morbid obesity is present. 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 as well as subliminal suggestion used to modify eating behaviors
c. Any medication or formula related to or resulting from the treatment of weight loss or obesity even if prescribed by a Professional Provider

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

9.31 Orthopedic Shoes
Except as provided for in section 8.8.3.

9.32 Orthognathic Surgery
Services and supplies associated with orthognathic surgery.

9.33 Pastoral and Spiritual Counseling

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

9.35 Physical Exercise Programs
Even if prescribed for a specific condition that is otherwise covered by the Plan, physical exercise programs are not covered.

9.36 Private Nursing Services
Are not covered even if they relate to a condition which is otherwise covered by the Plan.

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

9.38 Rehabilitation Services
Except as provided for in sections 8.6.8 and 8.6.5.

9.39 Reports and Records
Separate charges for the completion of reports, claim forms or treatment plans and the cost of records.

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

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

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

9.42 Self-Help Programs

9.43 Services Otherwise Available
Including those services or supplies:

a. for which payment could be obtained in whole or in part if a member had applied for payment under any city, county, state, or federal law, except for Medicaid coverage
b. for which a member cannot be held liable because of an agreement between the provider and another third party payer which has already paid or is obligated to pay for such service or supply
c. for which no charge is made, or for which no charge is normally made in the absence of health coverage
d. provided under separate contracts that are used to provide coordinated coverage for covered persons in a group and are considered parts of the same plan

e. a member could have received in a hospital or program operated by a government agency or authority. This exclusion does not apply to:

   i. Covered services provided at any hospital owned or operated by the State of Oregon or any state approved community mental health and developmental disabilities program
   ii. Covered services and supplies furnished by the Veteran's Administration of the United State to a member who is a veteran of the armed forces and receives care for medical condition that is not service-related is eligible for payment according to the terms of the Plan

9.44 Services Provided or Ordered by a Relative
Except for services by a dental provider or as specifically provided for in section 8.8.3, services provided by a member or his or her spouse or domestic partner, or a member's spouse or domestic partner, child, sibling, or parent of a member or any family member who lives in the member's home are not covered.

9.45 Services Provided By Volunteer Workers

9.46 Service Related Conditions
The Plan does not cover treatment of any condition caused by or arising out of services in the armed forces of any country or as a military contractor or from an insurrection or war, unless not covered by the member's military or veterans coverage.

9.47 Sexual Dysfunctions of Organic Origin
The Plan does not cover services or supplies for sexual dysfunction of organic origin, including impotence and decreased libido. This exclusion does not extend to sexual dysfunction diagnoses listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders.

9.48 Support Education
Including:

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

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

9.50 Taxes

9.51 Telehealth
Including telephone visits or consultations and telephone psychotherapy, except telemedicine as specifically provided for in section 8.7.26. This exclusion does not apply to covered case management services for behavioral health treatment.

9.52 Telephones and Televisions in a Hospital or Skilled Nursing Facility

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

9.54 Third Party Liability Claims
Services and supplies for treatment of a medical condition for which a third party is or may be responsible, to the extent of any recovery received from or on behalf of the third party (see section 10.4.2).

9.55 Transportation
Except medically necessary ambulance transport.

9.56 Treatment After Coverage Ends
The only exception is if a member is hospitalized at the time coverage ends (see section 8.1), or for covered hearing aids ordered before coverage ends and received with 90 days of the end date.

9.57 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.

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

9.59 Treatment Not Medically Necessary
Including services or supplies that are:

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

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.

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

9.61 Vision Care
Please see information on vision on section 8.11.

9.62 Vision Surgery
Any procedure to cure or reduce myopia, hyperopia, or astigmatism are not covered. Includes reversals or revisions of any such procedures and any complications of these procedures are not covered.

9.63 Vitamins and Minerals Dispensed by a Professional Provider
Except as required by law. Otherwise, not covered unless medically necessary for treatment of a specific medical condition (e.g., pre-natal) and prescribed and dispensed by a licensed professional provider under the medical benefit. This applies whether the vitamin or mineral is oral, injectable, or transdermal.

9.64 Work-Related Conditions
Treatment of a medical condition arising out of or in the course of employment or self-employment for wages or profit, unless the expense is denied as not work related under any workers' compensation provision. A claim must be filed for workers' compensation benefits and a copy of the workers' compensation denial letter must be submitted for payment to be considered. The exclusion does not apply to owners, partners or executive officers if they are exempt from workers' compensation laws and the Group does not provide workers' compensation coverage to them.

SECTION 10. CLAIMS ADMINISTRATION & PAYMENT

10.1 SUBMISSION & PAYMENT OF CLAIMS

A claim is not payable until the service or supply has actually been received. In no event, except absence of legal capacity or in the case of a Medicaid claim, is a claim valid if submitted later than 12 months from the date the expense was incurred. Claims submitted by Medicaid must be sent to Moda Health or WellDyneRx within 3 years after the date the expense was incurred. VSP Medicaid claims must be submitted within 1 year from date of service.

A claim for which additional information is received will not be reprocessed after the claim submission period, as described in the above paragraph.

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

10.1.1 Hospital & Professional Provider Claims

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

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

When a member is billed in full by the hospital or professional provider directly, he or she should send a copy of the bill to Moda Health, and include all of the following information:

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

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

For care received outside the United States, see section 10.1.6.

10.1.2 Other Healthcare Claims

Bills for other healthcare expenses not mentioned in sections 10.1.1 and sent directly to members should be submitted to Moda Health as they are received. Medical claims may also be submitted at regular intervals (for example, once a month).

10.1.3 Ambulance Claims

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

10.1.4 Prescription Medication Claims

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

A member who buys an OTC contraceptive or who fills a prescription at an out-of-network pharmacy will need to submit a request for reimbursement by completing the prescription medication claim form, which is available by contacting WellDyneRx.

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

10.1.5 Routine Vision Claims

To obtain Plan Benefits from an In-network Doctor, members should contact the In-network Doctor of their choice, identify themselves as a VSP member, and schedule an appointment. If they 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, members should pay the provider his/her full fee. Members 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. Members 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 members 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

10.1.6 Out-of-Country or Foreign Medical Claims

Out-of-country care is only covered for emergency or urgent care situations. When medical care is received outside the United States, the member must pay for services and submit all of the following information to Moda Health for reimbursement:

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

10.1.7 Explanation of Benefits (EOB)

Moda Health will report its action on a medical claim by providing the member a document called an Explanation of Benefits (EOB). Members are encouraged to access their EOBs electronically by signing up through myModa. The EOB will indicate if a claim has been paid, denied, or applied toward satisfying any deductible. If all or part of a claim is denied, the reason will be stated in the EOB.

If a member does not receive an EOB or an email indicating that an EOB is available within a few weeks of the date of service, this may indicate that Moda Health has not received the claim. To be eligible for reimbursement, claims must be received within the claim submission period explained in section 10.1.

If a member received treatment from an in-network provider, the EOB will also report any amounts charged by the provider that the member will not be required to pay.

10.1.8 Payment of Benefits

If Moda Health receives medical claims indicating that the member has assigned benefits to the provider, benefit payments will be made directly to that provider. If assignment of benefits has not been made, benefit payments will be issued directly to the subscriber.

10.1.9 Claim Inquiries

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

10.1.10 Time Frames for Processing Claims

If a medical claim is denied, Moda Health will send an EOB explaining the denial within 30 days after receiving the claim. If more time is needed to process the claim for reasons beyond Moda Health's control, a notice of delay will be send to the member explaining those reasons within 30 days after Moda Health receives the claim. Moda Health will then finish processing the claim and send an EOB to the member no more than 45 days after receiving the claim. If more information is needed to process of the claim, the notice of delay will describe the information needed and the party responsible for providing the additional information will have 45 days to submit it. Once the additional information is received, processing of the claim will be completed within 15 days. Submission of information necessary to process a claim is subject to the Plan's claim submission period explained in section 10.1.1.

10.1.11 Processing Time Frames for Prior Authorization

If a service must be prior authorized for a member to receive maximum plan benefits, Moda Health will respond to the authorization request for a medical service or supply within 2 business days. If additional information is needed, Moda Health will send a request within 2 business days and respond to the authorization within 15 days after receiving the authorization request. The response time will be expedited if the member has an urgent medical condition.

10.2 Complaints, Appeals & External Review

If a member disagrees with the outcome of a prior authorization or claim processing decision, there are specific procedures to request a review, as explained in this section. Please see section 8.11.8 for vision appeals process. Before filing an appeal, it may be possible to resolve a dispute with a phone call to Customer Service.

10.2.1 Definitions

Please see section 8.11.8 for VSP appeal process. For purposes of section 10.2, the following definitions apply:

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

a. rescission of coverage (see section 14.6.6)
b. Eligibility to participate in the Plan or prescription medication 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 8 and Section 9, including decision that an item or service is experimental or investigational or not medically necessary
f. Continuity of care (section 10.3) is denied because the course of treatment is not considered active

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

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

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

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

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

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

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

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

10.2.2 Time Limit For Submitting Appeals

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

10.2.3 The Review Process

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

If the appeal is about ending or reducing an ongoing course of treatment before the end of the authorized period of time or number of treatments, the Plan will continue to provide benefits while the appeal is being reviewed. If the decision is upheld, the member will have to pay back the cost of coverage received during the review period.

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

A member may review the claim file and submit written comments, documents, records, and other information to support the appeal. A member may choose a representative to act on his or her behalf.

10.2.4 First Level Appeals

An appeal must be submitted in writing to Moda Health for medical benefits, WellDyneRx for prescription medication benefits and VSP for vision care benefits. Please see section 8.11.8 for VSP appeal process. If necessary, Customer Service can help with filing an appeal. Moda Health or WellDyneRx will send a letter no more than 7 days after receiving an appeal to tell the member that the appeal was received. Appeals are investigated by persons who were not involved in the original decision.

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

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

10.2.5 Second Level Appeals

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

Investigations and responses to a second level appeal will be by persons who were not involved in the initial decisions, and will follow the same timelines as those for a first level appeal. The member may review the claim file and present evidence and testimony as part of the appeal process, and may appoint a representative to act on his or her behalf. If new or additional evidence or reasoning is used by Moda Health or WellDyneRx in connection with the claim, it will be provided to the member, in advance and free of charge, before any final internal adverse benefit determination. Members may respond to this information before a decision is finalized. Moda Health or WellDyneRx will notify the member in writing of the decision, the reason for the decision.

10.2.6 External Review

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

a. The member must sign a HIPAA release waiver allowing the IRO to see his or her medical records.
b. The request for external review must be in writing no more than the 180 days after receipt of the final internal adverse benefit determination. A member may submit additional information to the IRO within 5 days, or 24 hours for a fast review.
c. Generally, the member must have exhausted the appeal process described in sections 10.2.4 and 10.2.5. However, the Group may agree to skip this requirement and send an appeal directly to external review if the member agrees. For a fast appeal or when the appeal is about a condition for which a member received emergency services and is still hospitalized, a request for external review may be expedited or at the same time as a request for internal appeal review; and

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

a. An adverse benefit determination based on a utilization review decision
b. Whether a course or plan of treatment that a member is undergoing is an active course of treatment for purposes of continuity of care (see section 10.3)
c. Cases in which Moda Health or WellDyneRx does not meet the internal timeline for review or the federal requirements for providing related information and notices;

The decision of the IRO is binding except to the extent other remedies are available to the member under state or federal law.

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

10.2.7 Complaints

Moda Health or WellDyneRx will review complaints about the following issues when submitted in writing within 180 days from the date of the claim. Please see section 8.11.8 for VSP complaints and grievance process.

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

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

10.2.8 Additional Member Rights

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

Multnomah County Employee Benefits Office
501 SE Hawthorne, Suite 400
Portland, OR 97214
Telephone: 503-988-3477
FAX: 503-988-6257
Email: employee.benefits@multco.us

10.3 CONTINUITY OF CARE

10.3.1 Continuity of Care

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

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

Eligible members

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

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

Continuity of care ends

a. On the earlier of the following dates for most members:

    i. The day after the member finishes the active course of treatment that gives him or her the right to continuity of care
    ii. 120 days after the date Moda Health tells the member the contract with the professional provider has ended

b. On the later of the following dates for pregnancy care that is in at least the 2nd trimester:

    i. 45 days after the birth
    ii. As long as the member continues under an active course of treatment, but not later than 120 days after the date Moda Health tells the member the contract with the professional provider has ended

When continuity of care is not available:

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

10.4 Benefits Available From Other Sources

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

10.4.1 Coordination of Benefits (COB)

This provision applies when a member has healthcare coverage under more than one plan. A complete explanation of COB is in Section 11.

10.4.2 Third-Party Liability

A member may have a legal right to recover benefit or healthcare costs from a third party as a result of a medical condition for which such costs were paid by the Group.

The Group does not cover benefits for which a third party may be legally liable, except for those related to a motor vehicle accident (see section 10.4.3 for motor vehicle accident recovery). Because recovery from a third party may be difficult and take a long time, as a service to the member, the Group will pay a member's expenses based on the understanding and agreement that the Group is entitled to be reimbursed from any recovery the member may receive for any benefits paid that are or may be recoverable from a third party, as defined below.

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

10.4.2.1 Definitions:
For purposes of section 10.4.2 relating to Third Party Liability, the following definitions apply:

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

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

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

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

10.4.2.3 Right of Recovery
In addition to its subrogation rights, the Group may, at its sole discretion and option, require a member, and his or her attorney, if any, to protect its recovery rights. The following rules apply to all recovery except for those related to motor vehicle accidents (see section 10.4.3 for motor vehicle recovery rights):

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

b. The Group is entitled to receive the amount of benefits it has paid for that medical condition out of any settlement or judgment that results from exercising the right of recovery against the third party. This is so whether or not the third party admits liability or claims that the member is also at fault. In addition, the Group 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 Group requires the member, and his or her attorney, to protect the Group's recovery rights under this section, then the member may subtract from the money to be paid back to the Group a proportionate share of reasonable attorney fees as an expense for collecting from the other party.

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

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

10.4.2.4 Additional Provisions

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

a. The member shall cooperate with the Group to protect its recovery rights, including by:
   i. Signing and delivering any documents Moda Health reasonably requires to protect the Group's rights, including a Third Party Reimbursement Questionnaire and Agreement. If the member has retained an attorney, then the attorney must also sign the agreement.
   ii. Providing any information to Moda Health relevant to the application of the provisions of section 10.4.2, including all information available to the member, or any representative or attorney representing the member, relating to the potential third party claim. This may include medical information, settlement correspondence, copies of pleadings or demands, and settlement agreements, releases or judgments
   iii. Notifying Moda Health of the potential third party claim for which the Group may issue benefits. The member has this responsibility even if the first request for payment of benefits is a bill or invoice submitted to Moda Health by the member's provider
   iv. Taking such actions as Moda Health may reasonably request to assist it in enforcing the Group's third party recovery rights

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

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

d. The member agrees that Moda Health may notify any third party, or third party's representatives or insurers of the Group's recovery rights described in section 10.4.2.

e. Even without the member's written authorization, Moda Health may release to, or obtain from, any other insurer, organization or person, any information it needs to carry out the provisions of section 10.4.2.

f. Section 10.4.2 applies to any member for whom advance payment of benefits is made by the Group whether or not the event giving rise to the member's injuries occurred before the member became covered by the medical and prescription medication plans.

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

h. If the member or the member's representatives fail to do any of the above mentioned acts, then the Group has the right to not advance payment or to suspend payment of any benefits, or to recover any benefits it has advanced, for medical condition resulting from the event giving rise to, or the allegations in, the third party claim except for claims related to motor vehicle accidents (see section 10.4.3). Moda Health may notify medical providers seeking authorization of payment of benefits that all payments have been suspended, and may not be paid.

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

10.4.3 Motor Vehicle Accident Recovery

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

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

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

10.4.4 Surrogacy

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

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

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

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

10.5 MEDICARE – PARTS A AND B

The Plan coordinates benefits with Medicare as required under federal government rules and regulations. This includes coordinating to the Medicare allowable amount. To the extent permitted by law, if the Plan is secondary to Medicare, the Plan will not pay toward any part of a covered expense that is actually paid under Medicare or would have been paid(*) under Medicare Part B if the member had enrolled in Medicare when eligible. The Plan will estimate what Medicare would have paid and reduce its benefits based on the estimate. Medical benefits which are payable by the Plan will be paid in accordance with federal government rules and regulations on Medicare coordination of benefits in effect at the time. A member who chose not to enroll in Medicare when first eligible or canceled Medicare after initial enrollment may have to pay any expenses not paid by the Plan.

The Plan may estimate Medicare's payment when:

a. The member is on COBRA (does not apply to ESRD, below)
b. The member has end-stage renal disease (ESRD) and it is during the 30 months after he or she became eligible to enroll in Medicare

(*) Note: In the event a member, who is not covered as an active subscriber or Medicare-recognized dependent of an active subscriber becomes Medicare eligible and chooses to not enroll in Medicare, this Plan will estimate the Medicare benefit under Part B on any claims submitted for consideration and calculate this Plan's benefit based on that estimate.

SECTION 11. COORDINATION OF BENEFITS

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

11.1 DEFINITIONS

For purposes of this section on Coordination of Benefits, the following definitions apply:

Plan means any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for covered persons in a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts. Separate contracts do not include dual coverage when the employee and his or her spouse or domestic partner are employed by the Group and are covered as both subscribers and dependents.

Plan includes:

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

Plan does not include:

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

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

Complying Plan is a plan that follows these COB rules.

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

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

Claim Period means part or all of a plan year during which the claimant is covered under the Plan.

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

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

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

This Plan is the part of the group medical and prescription medication plans funded by the Group that provides benefits for healthcare expenses to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the group health plan providing healthcare benefits is separate from this Plan. The group health plan may apply one COB provision to certain benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

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

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

11.2 How COB Works

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

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

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

If the primary plan is a closed panel plan and the secondary plan is not a closed panel plan, the secondary plan shall provide benefits as if it were the primary plan when a member uses an out-of-network provider, except for emergency services or authorized referrals that are paid or provided by the primary plan.

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

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

11.3 Order Of Benefit Determination (Which Plan Pays First?)

The first of the following rules that applies will govern:

a. **Non-dependent/Dependent.** If a plan covers the member as other than a dependent, for example, an employee, member of an organization, primary insured, or retiree, then that plan will determine its benefits before a plan that covers the member as a dependent.

However, if the member is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the member as a dependent and primary to the plan covering the member as other than a dependent (e.g. a retired employee), then the order of benefits between the two plans is reversed.

b. **Dependent/Spouse (or Domestic Partner) and Parents.** For a dependent covered under plans of a spouse or domestic partner and his or her parents, the spouse's or domestic partner's plan is primary. The order of the parents' plans should follow the first applicable provision (c or d) below. This rule may no longer apply if future state or federal guidelines are issued to determine the order of coverage when a dependent is covered under plans of a spouse or domestic partner and his or her parents.

c. **Dependent Child/Parents Married, or Living Together.** If the member is a dependent child whose parents are married or are living together whether or not they have ever been married, the plan of the parent whose birthday falls earlier in the calendar year is the primary plan. If both parents' birthdays are on the same day, the plan that has covered the parent the longest is the primary plan. (This is called the 'Birthday Rule'.)

d. **Dependent Child/Parents Separated or Divorced or Not Living Together.** If the member is a dependent child of divorced or separated parents, or parents not living together whether or not they have ever been married, then the following rules apply:

   i. If a court decree states that one of the parents is responsible for the healthcare expenses of the child, and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to plan years commencing after the plan is given notice of the court decree.

   ii. If a court decree states that both parents are responsible for the healthcare expenses of the child, or that the parents have joint custody without specifying that one parent is responsible, the 'birthday rule' described above applies.

   iii. If there is not a court decree allocating responsibility for the child's healthcare expenses, the order of benefits is as follows: The plan covering the

      A. Custodial parent;
      B. Spouse or domestic partner of the custodial parent;
      C. Non-custodial parent; and then
      D. Spouse or domestic partner of the non-custodial parent.

e. **Dependent Child Covered by Individual Other than Parent.** For a dependent child covered under more than one plan of persons who are not the parents of the child, the first applicable provision (c or d) above shall determine the order of benefits as if those persons were the parents of the child.

f. **Dependent Child Coverage by Parent and Spouse.** For a dependent child covered under the plans of both a parent and a spouse or domestic partner, the length of coverage provision below shall determine the order of benefits. If coverage under either or both parents' plans and the spouse's/domestic partner's plan began on the same day, the birthday rule will apply.

g. **Active/Retired or Laid Off Employee.** The plan that covers a member as an active employee, that is, one who is neither laid off nor retired (or as that employee's dependent) determines its benefits before those of a plan that covers the member as a laid off or retired employee (or as that employee's dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of the benefits, this rule is ignored.

h. **COBRA or State Continuation Coverage.** If a member whose coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the member as an employee, member of an organization, primary insured, or retiree or as a dependent of the same, is the primary plan and the COBRA or other continuation coverage is the secondary plan. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of the benefits, this rule is ignored.

i. **Longer/Shorter Length of Coverage.** The plan that covered a member longer is the primary plan and the plan that covered the member for the shorter period of time is the secondary plan.
j. **None of the Above.** If the preceding rules do not determine the order of benefits, the allowable expenses shall be shared equally between the plans. In addition, this Plan will not pay more than it would have paid had it been the primary plan.

11.4 EFFECT ON THE BENEFITS OF THIS PLAN

When this Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a plan year are not more than the total allowable expenses. In determining the amount to be paid for any claim, the secondary plan will calculate the benefits it would have paid in the absence of other healthcare coverage and apply that calculated amount to any allowable expense under its plan that is unpaid by the primary plan. The secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other healthcare coverage.

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

11.5 PHARMACY (COB)

Claims subject to the COB provision of the Plan may be submitted electronically by pharmacies or through the direct member reimbursement paper claim process. The preferred method is for the pharmacy to electronically transmit the primary plan's remaining balance to WellDyneRx for processing. If approved, the secondary claim will be automatically processed according to plan benefits. Members who are unable to have their secondary claims processed electronically may submit a claim reimbursement request directly to WellDyneRx (see section 10.1.4).

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

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

Approved by Primary:

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

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

11.6 COORDINATION WITH MEDICARE

Retired Members, COBRA members and enrolled domestic partners with age based Medicare entitlement, who are eligible for Medicare Parts A and B, but have declined to enroll in Medicare are still subject to coordination of benefits. Moda Health will estimate the benefits payable by Medicare Part B and process claims from the secondary position based on those estimates.

SECTION 12. MISCELLANEOUS PROVISIONS

12.1 Right to Collect & Release Needed Information

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

12.2 CONFIDENTIALITY OF MEMBER INFORMATION

Keeping a member's protected health information confidential is very important. Protected health information includes enrollment, claims, and medical and prescription medication information. Such information is used internally for claims payment, referrals and authorization of services, and business operations such as case management and quality management programs. Moda Health, WellDyneRx and VSP do everything possible to protect PHI. The Notice of Privacy Practices provides more information about how the Group uses such information. Moda Health, WellDyneRx and VSP as the third party administrators are required to adhere to these same practices. Members may contact the Group if they have additional questions about the privacy of their information beyond that provided in the Notice of Privacy Practices.

12.3 TRANSFER OF BENEFITS

Only members are entitled to benefits under the medical and prescription medication plans. These benefits are not assignable or transferable to anyone else. Any attempted assignment or transfer will not be binding on Moda Health, WellDyneRx, VSP nor the Plan, except that the Group shall pay amounts due under these plans directly to a provider upon a member's written request.

12.4 RECOVERY OF BENEFITS PAID BY MISTAKE

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

12.5 CORRECTION OF PAYMENTS

If benefits that the medical or prescription medication plan should have paid are instead paid by another plan, the other plan may be reimbursed. Amounts reimbursed are plan benefits and are treated like other plan benefits in satisfying the liability under the medical or prescription medication plan.

12.6 CONTRACT PROVISIONS

The agreement between the Group and Moda Health, the agreement between the Group and WellDyneRx, and this handbook plus any endorsements or amendments are the entire contract between the various 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.

12.7 REPLACING ANOTHER PLAN

For persons covered on an earlier Moda Health plan, WellDyneRx plan, VSP plan or other Group Health Plan that the Group replaces, provided they remain eligible for coverage according to the requirements of the medical and prescription medication plans, benefits and deductibles will be applied as follows:

a. Benefits under these medical and prescription medication plans reduced by any benefits payable by the prior plan. This replacement provision does not apply to any person excluded from coverage under these plans because the person is otherwise covered under another policy with similar benefits.
b. Credit shall apply for the satisfaction or partial satisfaction for any deductibles met under the prior plan for the same or overlapping benefit periods with the medical or prescription medication plan, but the credit shall apply or be given only to the extent that the expenses are recognized under the terms of the replacement plan and are subject to a similar deductible provision.

12.8 RESPONSIBILITY FOR QUALITY OF MEDICAL CARE

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

12.9 WARRANTIES

All statements made by the Group or a member, unless fraudulent, are considered representations and not warranties. No statement made for the purpose of obtaining insurance 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.

12.10 No Waiver

Any waiver of any provision of the medical and prescription medication plans, or any performance under these plans, 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, VSP or the Group fails to exercise any right, power or remedy provided in these plans, including, a delay or omission in denying a claim that shall not waive any rights to enforce the provisions of these plans by Moda Health, WellDyneRx and VSP.

12.11 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.

12.12 Governing Law

To the extent the medical and prescription medication plans are governed by state law, they shall be governed by and construed in accordance with the laws of the State of Oregon.

12.13 Where Any Legal Action Must Be Filed

Any legal action arising out of the medical or prescription medication plan must be filed in either a state or federal court in the State of Oregon.

12.14 Time Limits For Filing A Lawsuit

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

12.15 Evaluation Of New Technology

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

SECTION 13. ELIGIBILITY

The date a person becomes eligible to Enroll may be different than the date coverage begins (see sections 14.1 and 14.2).

The Group's eligibility provisions provide broader dependent eligibility rules for coverage than IRS regulations which govern the Plan. If the subscriber elects 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 the actively employed subscriber will pay tax on the value of the coverage for that enrolled dependent.

13.1 SUBSCRIBER

13.1.1 Non-Represented Employees

A person is not eligible to enroll under the Plan if he or she works in a Non-Represented position for the Group.

13.1.2 Represented Employees

Employees are eligible to enroll in the Plan if they are covered by the AFSCME Local 88 Juvenile Custody Service Specialists Contract, the AFSCME Local 88-4 Physicians Contract, or International Brotherhood of Electrical Workers Local 48 and meet the eligibility criteria stated in the labor contract.

Employees may be eligible to remain covered while on an approved leave of absence under state or federal family and medical leave laws.

13.1.3 Retirees

Retirees 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. Retirees are not eligible to enroll under the Plan if he or she retired from the Group from a position not listed in Section 13.1.2. Retirees may be allowed to waive retiree coverage and sign up at a later date if covered continuously by another group plan.

13.1.4 COBRA Eligibility

Members may be able to continue coverage under COBRA provisions if they are no longer eligible for coverage under this Plan. Members should check with the Group's benefits office to find out whether or not they qualify for COBRA (see Section 15). Benefits under COBRA continuation are the same as the current Plan.

13.2 DEPENDENTS

A subscriber's 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. Children of the subscriber and children of the subscriber's 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 the subscriber to provide health coverage. **Eligible dependents must be properly enrolled in order to obtain coverage**. Actively employed subscribers must accurately report the relationship of all children so it can be

determined whether his or her 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 the actively employed subscriber.

The subscriber is 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 the subscriber's biological child, step-child, adopted child, child in the subscriber's custody pending adoption, a child for whom the subscriber is required by court order to provide coverage, a child for whom the subscriber is 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.

13.2.1 Extension of Coverage for Children with Disability

If a subscriber has an enrolled dependent child who would lose eligibility for coverage based on age and is physically or mentally incapable of self-support due to a condition, the child may be eligible for coverage beyond the age limit under this provision. To remain eligible, the following conditions must be satisfied:

a. The child must have been enrolled in the Plan and have had continuous medical coverage prior to the age triggered loss of eligibility, and
b. The child must be unmarried, not registered as anyone's domestic partner under the Oregon Family Fairness Act, and principally dependent on the subscriber for support, and
c. The disability must have arisen before the age triggered loss of eligibility, and
d. The subscriber must provide Moda Health with a written physician's statement confirming the child has a condition rendering the child physically or mentally incapable of self-support and that the condition existed continuously prior to the loss of eligibility. Social Security Disability status does not guarantee coverage under this provision.

Documentation of the child's medical condition must be reviewed and approved by a Moda Health medical consultant in order for the child to remain covered. **This initial review must be completed in advance of the child losing eligibility for coverage**. The documentation should be submitted at least 45 days before the child's 26th birthday.

a. Recent medical or psychiatric progress notes and evaluations, referrals or consult notes
b. Relevant test results (e.g., lab, imaging, neuro-psychiatric testing, etc.)
c. Recent hospitalization records (e.g., history and physical, discharge summary) if applicable
d. Disability information from prior carrier

Moda Health will make an eligibility determination based on documentation of the child's medical condition. Periodic review by Moda Health will be required on an ongoing basis except in cases where the disability is certified to be permanent.

13.3 QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

The Plan will cover a child of an eligible employee who has a right to enrollment due to a Qualified Medical Child Support Order (QMCSO). The Plan has detailed procedures for determining whether an order qualifies as a QMCSO. A copy of such procedures is available from the Group without charge.

The child's coverage under the Plan will be effective as of the first day of the month following the date that the Group determines that applicable order qualifies as a QMCSO, and that the child is eligible for enrollment in the Plan.

13.4 NEW DEPENDENTS

Generally a subscriber has 60 days from the date he or she obtains 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 the subscriber fail to submit an enrollment during the enrollment period, he or she may have to wait until the next annual open enrollment in order to add the new dependent to coverage.

13.4.1 Marriage

If a subscriber marries while covered under the Plan, the spouse and his or her dependent children become eligible for enrollment under the Plan. The subscriber must submit enrollment and an Affidavit of Marriage or Domestic Partnership form. The form must be completed, signed, 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 following the date the Group receives the completed enrollment documentation.

13.4.2 Domestic Partnership – State Registered

State of Oregon Domestic Partner Registry: If a subscriber establishes a domestic partnership and obtains a certificate from the State of Oregon's Domestic Partner Registry, the domestic partner and his or her children become eligible for enrollment under the Plan. The subscriber must submit enrollment and an Affidavit of Marriage or Domestic Partnership form. The form must be completed, signed and submitted during the 60 days immediately following the domestic partner registry. If submitted during the 60 day enrollment period, coverage begins the first of the month following the date the Group receives completed enrollment documentation.

13.4.3 Domestic Partnership – Multnomah County Registered

Multnomah County Domestic Partner Registry: If a subscriber establishes a domestic partnership and obtains a certificate from the Multnomah County Domestic Partner Registry, the domestic partner and his or her children become eligible for enrollment under the Plan. The subscriber must submit enrollment and an Affidavit of Marriage or Domestic Partnership form. The form must be completed, signed and submitted during the 60 days immediately following the domestic partner registry. If submitted during the 60 day enrollment period, coverage begins the first of the month following the date the Group receives completed enrollment documentation.

13.4.4 Domestic Partnership – Shared Residency

Based on Shared Residence: If a subscriber establishes a domestic partnership and does not obtain a certificate from the Multnomah County Domestic Partner Registry or the State of Oregon's Domestic Partner Registry, the domestic partner and his or her 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. The subscriber must submit enrollment and an Affidavit of Marriage or Domestic Partnership form. The form must be completed and signed 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 following the date the Group receives completed enrollment documentation.

13.4.5 Newborn Child

Subscriber's newborn child is automatically eligible for coverage under the Plan for 31 days following birth. During this period the subscriber 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 the subscriber has 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.

13.4.6 Newborn Child Of An Enrolled Child

A newborn of a subscriber's enrolled child is automatically eligible for coverage under the Plan for 31 days following birth. The subscriber 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 23, and enrolled as a dependent under the Plan, and
b. The subscriber must request enrollment for the grandchild within 60 days of birth, and
c. The grandchild's birth parent must remain unmarried, under age 23 and otherwise eligible and enrolled for coverage as a dependent under the Plan, and
d. Both the grandchild and birth parent reside in the subscriber's home.

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, the subscriber would need to obtain legal guardianship of the grandchild in order to retain coverage as a dependent.

Limitations

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

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

13.4.7 Adopted Child

Adopted children are eligible from the date of the adoption decree. A child who is placed with the subscriber pending the completion of adoption proceedings will become eligible on the date of placement with the subscriber. 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.

The subscriber must enroll to continue coverage beyond the first 31 days. The enrollment must be submitted to the Group within 60 days of the child's adoption or placement for adoption.

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

13.4.8 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 who is an active Employee (taxpayer):

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 his or her 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.

13.4.9 Imputed Income Tax on Non-IRS Eligible Covered Dependents' Benefits

For subscribers who are active employees 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 actively employed subscriber's income when determining income and payroll taxes;
c. Report the income on actively employed subscriber's W-2
d. Withhold employee contributions for these dependents' coverage on a post-tax basis; and
e. Not permit Health Care Flexible Spending Accounts to be used for the reimbursement of these dependents' uninsured expenses.

SECTION 14. ENROLLMENT

This section explains how to enroll in the Plan. Once covered, it is the subscriber's 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 14.6.2; or
c. partial last month coverage for a subscriber immediately preceding his or her death.

14.1 WHEN AN EMPLOYEE FIRST BECOMES ELIGIBLE

New Hire: A submitted enrollment for the eligible employee/subscriber and any dependents to be enrolled must be submitted within 31 days of subscriber's date of hire. If enrolling a spouse and/or domestic partner the subscriber must also complete an Affidavit of Marriage or Domestic Partnership.

The amount of the employee's share of the monthly premium is different for full-time and/or part-time employees. Please review the enrollment brochure 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 following enrollment. If the first of the month is a business day and enrollment is submitted on that day, coverage will begin immediately.**
b. If enrollment is not submitted within the 31-day enrollment period, the employee 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.

14.2 ENROLLING NEW DEPENDENTS

A subscriber may obtain coverage for newly acquired or newly eligible dependents by completing enrollment and appropriate Affidavit 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 following enrollment and appropriate Affidavit. If the first of the month is a business day and enrollment is submitted on that day, coverage will begin immediately.**
b. If enrollment is not submitted during the 60-day enrollment period, the subscriber 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. To continue coverage, the subscriber must submit an enrollment within 60 days of birth, adoption or placement of adoption. Otherwise, coverage for the child will remain terminated on the 31st day post birth

and the subscriber will be unable to re-enroll the child until the next annual open enrollment (see section 14.4).

14.3 Opt-Out Provision

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

If an eligible employee waives coverage because he or she has coverage under another group medical plan, he or she may drop the Opt-Out election to enroll in a County health Plan within 60 days of losing the other coverage outside of the annual Open Enrollment period. Their medical/vision/prescription coverage effective date will be the first day of the month following enrollment, appropriate Affidavit, and documentation confirming the termination date of the other medical coverage.

14.4 Annual Open Enrollment

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

An eligible person may not need to wait until the annual open enrollment period to enroll if:

a. The person qualifies for special enrollment as described in section 14.5;
b. A court has ordered that coverage be provided for a spouse/domestic partner or minor child under a subscriber's health benefit plan and request for enrollment is made within 60 days after issuance of the court order;
c. The person is employed by an employer who offers multiple health benefit plans and the person elects a different health benefit plan during a special open enrollment period; or
d. The person's 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.

14.5 Special Enrollment Rights

14.5.1 Loss of Other Coverage

If coverage is declined when initially eligible or at an open enrollment period because of other health coverage, an eligible employee or any dependent(s) may enroll in the Plan outside of the open enrollment period if the following criteria are met:

a. He or she was covered under a group health plan or had health insurance coverage at the time coverage was previously offered;
b. He or she stated in writing at such time that coverage under a group health plan or health insurance coverage was the reason enrollment was declined;
c. He or she requests such enrollment not later than 60 days after the previous coverage ended; and
d. One of the following events has occurred:

    i. His or her prior coverage was under COBRA continuation provision and the coverage under such provision was exhausted, this includes reaching the lifetime maximum while on COBRA coverage.
    ii. His or her prior coverage ended as a result of loss of eligibility for the coverage. Examples of when coverage under a plan may be lost include:
        A. legal separation or divorce
        B. dissolution of Domestic Partnership
        C. loss of Dependent status per plan terms
        D. death
        E. end of employment
        F. reduction in the number of hours of employment
        G. reaching the lifetime maximum on all benefits
        H. the plan stops offering coverage to a group of similarly situated persons
        I. moving out of an HMO Service Area that causes coverage to end and no other option is available under the plan
        J. termination of the benefit packet option, and no substitute option is offered
    iii. The employer contributions toward his or her other active (not COBRA) coverage ended. (If employer contributions stop, the eligible employee or dependent does not have to end coverage in order to be eligible for special enrollment on a new plan.)
    iv. His or her prior coverage was under Medicaid or a children's health insurance program (CHIP) and such coverage ended due to loss of eligibility.

Coverage under special enrollment due to loss of coverage begins on the first day of the month following enrollment, or coinciding with, but not before the loss of other coverage.

14.5.2 Eligibility Due to Premium Subsidy

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

14.5.3 Acquisition of New Dependents

When an eligible employee or subscriber acquires a new dependent through birth, marriage, domestic partnership, adoption or placement of adoption, the eligible employee or subscriber, spouse or domestic partner and children will have special enrollment rights if they are not enrolled at the time of the event that caused the eligible employee or subscriber 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 following the date the Group receives the enrollment and Affidavit of Marriage/Domestic Partnership.

If the first of the month is a business day and enrollment is submitted on that day, coverage will begin immediately.

b. **Birth:** Infant is automatically covered for the first 31 days following birth. A subscriber 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.

14.6 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 14.6.4 or Section 15.

14.6.1 Plan Termination

Coverage ends for the Group and members on the date the Plan ends. There is one exception to this rule. If the Group terminates the Plan and a member is hospitalized on the day the Plan ends, the Plan shall continue its obligation for benefits until the hospital confinement ends or hospital benefits under the Plan are exhausted, whichever is earlier. Any payment required under this provision is subject to all terms, limitations and conditions of the Plan, except those relating to termination of benefits.

14.6.2 Extension of Benefits

When a member is an inpatient in the hospital on the day coverage ends, the Plan will continue to pay towards the covered services for that hospitalization until the member is 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, to a member who is totally disabled and under the care of a physician or surgeon at the time his or her coverage under the Plan ends. For purposes of this section, "totally disabled" means, when applied to the member, that due to a medical condition, he or she is prevented from engaging in any work for wage or profit. A member will also be considered totally disabled when prevented by a medical condition from engaging in all of his or her regular activities customary for a person of that age.

The Plan must be given medical proof of the disability and its continuation within 60 days after the member's coverage ends; and from time to time Moda Health 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 the person was 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 the member is receiving COBRA benefits.

14.6.3 Termination by a Subscriber

If a subscriber obtains other group health coverage, or is covered as a dependent on other health coverage, the subscriber may be able to terminate his or her coverage with the Group while still actively employed. The subscriber will need to submit an enrollment choosing the Opt-Out option, and submit an opt out affidavit, within 60 days from the date the new coverage starts.

The Plan's coverage end date will be the last day of the month following receipt of the completed enrollment change request, or, if the first of the month is a business day and enrollment is processed on that day, coverage will end on the last day of the prior month.

14.6.4 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 cause 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 15).

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 15 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 15 for details).

If any subscriber dies, and his or her legal spouse or same sex 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 same sex Domestic Partner, and any enrolled dependent children under the Plan may continue their coverage under the Plan if they meet the requirements in section 14.6.14.

14.6.5 Loss of Eligibility

If a subscriber is no longer eligible, coverage will end for the subscriber and any enrolled dependents according to the terms described in the labor agreement or Personnel Rule for non-represented employee benefits. However, a subscriber and enrolled dependents may have the right to continue coverage by purchasing the coverage on their own. See the "Continuation of Coverage" section.

14.6.6 Rescission

The Plan may rescind a member's coverage back to the effective date, or deny claims at any time for fraud or intentional material misrepresentation by the member, which may include but are not limited to enrolling ineligible persons on the Plan, falsifying or withholding documentation or information that is the basis for eligibility, or employment, falsification or alteration of claims. The Plan reserves the right to retain premiums paid as liquidated damages, and the member shall be responsible for repayment of the full balance of any benefits paid. A member will be notified of the rescission 30 days prior to cancellation of coverage.

14.6.7 Family and Medical Leave

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

a. Affected members will remain eligible for coverage during the approved FMLA leave.
b. The subscriber's rights under FMLA will be governed by applicable state or federal statute and regulations.

If a subscriber is unpaid during a period of leave, the subscriber's cost shares will be recovered by the Group upon subscriber's return to work.

14.6.8 Leave of Absence

If a subscriber is granted a non-FMLA leave of absence by the Group, group sponsored coverage will end after the initial 30 days of leave, unless the subscriber returns to work for the Group. 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. Once the group sponsored coverage ends, the subscriber and any enrolled dependents may continue coverage under the Plan by purchasing the coverage on their own (see Section 15).

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

14.6.9 Strike or Lockout

If employed under a collective bargaining agreement and involved in a work stoppage because of a strike or lockout, a subscriber may continue coverage for up to 6 months. The subscriber must pay the full premiums, including any part normally paid by the Group, directly to the union or trust, and the union or trust must continue to pay the premiums to the Group on the monthly due date.

Coverage cannot be continued if fewer than 75% of those normally covered continue coverage or if a subscriber otherwise loses eligibility under the Plan.

14.6.10 Termination of Employment

If a subscriber's active employment terminates with the Group, coverage will end for the subscriber 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. Members may have the opportunity to continue coverage under the Plan (see section 13.1.3 or Section 15).

Should a subscriber's active employment with the Group end, then subscriber is rehired by the Group and returns to active work within the same plan year:

If no open enrollment period has occurred during the subscriber's absence: The subscriber 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 following the subscriber's rehire date, unless the rehire date (first working date) is the first of the month, then benefits will begin immediately. Example: Hire date October 1, First working day October 1, coverage restarts October 1. Example: Hire date October 1, First working day October 2, coverage restarts November 1.

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

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

14.6.11 Termination of Coverage due to Reduction in Hours

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

If no open enrollment period has occurred during the period of non-coverage: The subscriber 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 following the subscriber's work hours increase date, unless his or her start date is the first of the month, then benefits will begin immediately.

The subscriber has experienced a family status change during the period of non-coverage is working at a different FTE or Bargaining Unit: Subscriber may be able to request a change to the previous benefit elections (the subscriber can contact the Group for more information.)

If an open enrollment period occurred during the period of non-coverage: The subscriber must complete and submit a Benefit Enrollment form in order to Enroll and initiate coverage. In this situation, the subscriber has the option of changing his or her previous plan elections or keeping the same elections but the enrollment form is required.

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

The Group must notify Moda Health that the subscriber is being rehired following a termination of employment or his or her hours have been increased.

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

14.6.12 Loss of Eligibility by Children

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

a. The child turns 26 years of age, or
b. The child reaches the age of majority or the age specified by the court, if the child is under legal guardianship of the subscriber, or
c. A grandchild ceases to meet the eligibility requirements specified in Section 13.4.6, or
d. A child with disability ceases to meet the eligibility requirements specified in Section 13.2.1.

Coverage will end on the last day of the month in which the child's eligibility ends. The subscriber will need to submit a timely request for the enrolled dependent's removal from coverage to the Group. The subscriber (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 15.

14.6.13 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, the subscriber (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 15.

Note
It is the subscriber's 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 the subscriber.

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

Note: In section 14.6.14 the term "Domestic Partner" refers only to a State Registered Domestic Partner, as defined in Section 5.

a. Introduction
The Plan offers enrolled spouses and enrolled domestic partners the opportunity to request a temporary extension of health coverage for themselves and their dependents if coverage is lost due to a specific event identified in the following paragraphs ("55+ Oregon Continuation").

The Plan will provide 55+ Oregon Continuation coverage to members who elect this coverage:

a. The Plan will offer no greater rights than Oregon law requires
b. The Plan will not provide 55+ Oregon Continuation coverage for members who do not comply with the requirements outlined below
c. The Group is responsible for providing the required notices within the statutory time periods, including the notice of death and the election notice. If the Group fails to notify the eligible spouse or domestic partner, premiums shall be waived from the date the notice was required until the date notice is received by the spouse or domestic partner. The Group shall be responsible for such premiums

b. Eligibility Requirements for 55+ Oregon Continuation Coverage
The enrolled spouse or domestic partner of the subscriber may elect 55+ Oregon Continuation coverage for himself or herself and any enrolled dependents if the following requirements are met:

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

c. Notice & Election Requirements for 55+ Oregon Continuation Coverage
Notice of Divorce, Dissolution, or Legal Separation. Within 60 days of legal separation or the entry of a judgment of dissolution of marriage or Oregon State Registered Domestic Partnership, a member who is eligible for 55+ Oregon Continuation and seeks such coverage shall give the Group written notice of the legal separation or dissolution. The notice shall include his or her mailing address.

Notify the Group at:

Multnomah County – Employee Benefits Office
501 S.E. Hawthorne Blvd. Suite 400
Portland, OR 97214

Election Notice in the event of Subscriber's Death. Within 44 days of the death of the subscriber, the Group shall provide notice to the surviving, legally separated or divorced spouse or domestic partner that coverage can be continued, along with an election form. If the Group does not provide this election notice within the required timeframe, premiums shall be waived until the date notice is received.

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

d. Premiums

Monthly premiums for 55+ Oregon Continuation are limited to 102% of the premiums paid by a current subscriber. The first premium shall be paid by the surviving, legally separated or divorced spouse or domestic partner to the Group within 45 days of the date of election. All remaining monthly premiums must be paid within 30 days of the premium due date. Coverage is not in force unless premium payment has been received by the Group on month to month basis. The premium for this coverage generally changes each January 1.

e. When Coverage Ends

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

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

14.6.15 Uniformed Services Employment & Reemployment Rights Act (USERRA)

Under USERRA, certain rights are guaranteed to a subscriber who is an active employee and is called to active duty by any of the armed forces of the United States of America. However, the Group has elected to provide coverage in excess of what this law requires. While the subscriber is on active duty, coverage will be continued for the period of uniformed service leave. The Group will waive the subscriber's cost shares that accumulate during this period not to exceed 5 years.

Should continuation coverage under USERRA be terminated or become exhausted, coverage will be reinstated on the first day he or she returns to active employment with the Group if released under honorable conditions, but only if he or she returns to active employment within time frames as set forth by the Group.

Regardless of the length of the service-related leave, a reasonable amount of travel time or recovery time for a medical condition determined by the Veteran's Administration (VA) to be service connected will be allowed between discharge and the subscriber's return to work, provided the subscriber has notified the Group of that medical condition.

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

SECTION 15. CONTINUATION OF COVERAGE (COBRA)

The following sections on continuation of coverage (COBRA) may apply. Members should check with the Group's benefits office to find out whether they qualify for this coverage. Both the subscriber and their enrolled dependents should read the following sections carefully.

15.1 INTRODUCTION

The Group will provide COBRA continuation coverage to members who have experienced a qualifying event and who elect coverage under COBRA, subject to the following conditions:

a. Other than the exception to offer domestic partner coverage, the Group is not obligated to offer greater rights than the COBRA statute requires
b. The Group will not provide COBRA coverage for members who do not comply with the requirements outlined below

15.2 QUALIFYING EVENTS

Subscriber
A subscriber covered by the Plan may elect continuation coverage if coverage is lost because of termination of employment (other than termination for gross misconduct on the subscriber's part) or a reduction in hours.

Spouse or Domestic Partner
The spouse or domestic partner of a subscriber covered by the Plan has the right to choose continuation coverage if coverage is lost for **any** one of the following five qualifying events:

a. Death of the subscriber
b. Termination of the subscriber's employment (for reasons other than gross misconduct) or reduction in a subscriber's hours of employment
c. Divorce from the subscriber
d. Termination or dissolution of a qualifying domestic partnership
e. The Subscriber becomes entitled to Medicare

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

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

a. Death of the subscriber
b. Termination of the subscriber's employment (for reasons other than gross misconduct) or reduction in a subscriber's hours of employment with the Group
c. Parent's divorce or termination of a qualifying domestic partnership
d. The subscriber becomes entitled to Medicare

e. The child ceases to be a "child" under the Plan

15.3 OTHER COVERAGE

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

15.4 NOTICE & ELECTION REQUIREMENTS

Qualifying Event Notice. A member's coverage ends on the date according to section 14.6 when a divorce or termination or dissolution of domestic partnership occurs (spouse's or domestic partner's coverage is lost) or a child loses dependent status under the Plan (child loses coverage). Under COBRA regulations, the subscriber or a family member has the responsibility to notify the COBRA Administrator if one of these events occurs by email, mailing or hand-delivering a written notice to the COBRA Administrator. The notice must include the following:

a. the name of the Group for the Plan
b. the name and personal identification number of the member(s)
c. the affected member(s)
d. the event (e.g. divorce)
e. the date the event occurred

Notice must be given to the COBRA Administrator no later than 60 days after the event causing loss of coverage under the Plan occurs. Notice should be sent by email or mail to:

Multnomah County – Employee Benefits Office
501 S.E. Hawthorne Blvd. Suite 400
Portland, OR 97214
employee.benefits@multco.us

Election Notice. Members will be notified of their right to continuation coverage and the process for completing COBRA enrollment and premium payment within 14 days after the COBRA Administrator receives the notice. COBRA coverage is not in force until enrollment is complete and premium payment is made. If the subscriber or dependent fails to provide notice of a qualifying event within the 60 day period, COBRA continuation of coverage will not be available.

Otherwise, members will be notified by the COBRA Administrator of the right to elect COBRA continuation coverage within 14 days of any of the following events that result in a loss of coverage:

a. the subscriber's termination of employment (other than for gross misconduct)
b. the subscriber's reduction in hours
c. death of the subscriber
d. the subscriber's becoming entitled to Medicare

Election Process (Member Responsibility). A member must elect continuation coverage within 60 days after Plan coverage ends, or, if later, 60 days after the COBRA Administrator sends the member notice of the right to elect continuation coverage. If continuation coverage is not elected and paid for the group health coverage will end on the date determined by the qualifying event. Elected COBRA coverage is not in force until premium has been paid.

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

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

15.5 COBRA PREMIUMS

Members are responsible for all premiums for continuation coverage. Due to the 60-day election period, it is likely that retroactive premiums will be owed for the months between when regular coverage ended and the first payment date. These premiums must be paid in a lump sum at the first payment. The first payment for continuation coverage is due within 45 days after a member provides notice of electing coverage (this is the date the election notice is postmarked, if mailed, or the date the election notice is received by the COBRA Administrator, if hand-delivered).

Subsequent monthly premium payments are due on the first day of the coverage month. For example, premium for October coverage is due on October 1. There will be a grace period of 30 days to pay the premiums (for example, a member would have until October 31st to pay the October premium). Payment of premium received after the due date but within the grace period may result in delayed access to coverage. Monthly eligibility is not updated until premium payment is received.

The COBRA administrator will not send a monthly bill for any payments due. The member is responsible for paying the applicable premiums when due; **otherwise continuation coverage will end and may not be reinstated**. The premium rate may include a 2% add-on to cover administrative expenses.

15.6 LENGTH OF CONTINUATION COVERAGE

18-Month Continuation Period. In the case of a loss of coverage due to end of employment (other than for gross misconduct) or a reduction of hours of employment, coverage generally may be continued for up to a total of 18 months.

36 Month Continuation Period.
When coverage is lost due to a subscriber's death, divorce, termination or dissolution of a qualified domestic partnership, the subscriber's becoming entitled to Medicare, or a child ceasing to be a dependent under the terms of the Plan, coverage under the Plan may be continued for up to a total of 36 months.

When the qualifying event is the end of employment (other than for gross misconduct) or reduction of the subscriber's hours of employment, and the subscriber became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA coverage for members other than the subscriber who lose coverage as a result of the qualifying event can last up to 36 months after the date of Medicare entitlement. This COBRA coverage period is available only if the subscriber becomes entitled to Medicare within 18 months BEFORE the termination or reduction of hours.

15.7 EXTENDING THE LENGTH OF COBRA COVERAGE

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

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

The disability extension is available only if the Social Security Administration determination is within the 18-month period following the subscriber's termination of employment or reduction of hours. The member must provide a copy of the Social Security Administration's determination of disability to the COBRA Administration within 60 days after the latest of:

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

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

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

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

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

Note: A longer period for continuation coverage may be available under Oregon Law for a subscriber's spouse or Oregon state Domestic Partner-Registered age 55 and older who loses coverage due to the subscriber's death, or due to legal separation or divorce or dissolution of an Oregon State Registered Domestic Partnership (see section 14.6.14).

15.8 Newborn or Adopted Child

If a child is born to or placed for adoption with a subscriber, the child is considered a qualified beneficiary. The subscriber may elect continuation coverage for the child provided the child satisfies the otherwise applicable Plan eligibility requirements (for example, age). The subscriber 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.

15.9 Special Enrollment & Open Enrollment

Under continuation coverage, qualified beneficiaries have the same rights afforded similarly-situated members who are not enrolled in COBRA. A qualified beneficiary may add children, spouse or domestic partner as enrolled dependents in accordance with the Plan's eligibility and enrollment rules (see section 14.4 and 14.5), including HIPAA special enrollment. If non-COBRA members can change plans at open enrollment, COBRA members may also change plans at open enrollment.

15.10 When Continuation Coverage Ends

COBRA coverage will end earlier than the maximum period if:

a. The Group no longer provides health coverage to any of its employees
b. The required premium is not paid in full on time
c. A member becomes covered under another group health plan
d. A member becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing COBRA
e. During a disability extension period (see 15.7), the disabled member is determined by the Social Security Administration to be no longer disabled (COBRA coverage for all members, not just the disabled member, will terminate)

COBRA coverage may also be canceled for any reason the Plan would terminate coverage of a member not receiving COBRA coverage (such as fraud).

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.

Questions about COBRA should be directed to the COBRA Administrator. 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.

SECTION 16. MEMBER DISCLOSURES

1. What are a Member's rights and responsibilities?

Members have the right to:

a. Information about the Plan and how to use it, about the providers who will care for them, and about their rights and responsibilities.
b. Be treated with respect and dignity.
c. Urgent and emergency services, 24 hours a day, 7 days a week.
d. Participate in decision making regarding their healthcare. This includes:
    i. a discussion of appropriate or medically necessary treatment options no matter how much they cost or if they are covered by the Plan
    ii. the right to refuse treatment and be informed of the possible medical result
    iii. File a statement of wishes for treatment (i.e., an Advanced Directive), or give someone else the right to make healthcare choices when the member is unable to (Power of Attorney)
e. Privacy. Personal and medical information only be used or shared as required or allowed by state and federal law, and will be given to third parties only as necessary to administer the plan, as required by 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 the Plan.
h. Make suggestions regarding the Plan's member rights and responsibilities policy.

Members have the responsibility to:

a. Read this handbook and make sure they understand the medical and prescription medication plans. Members should call Moda Health Customer Service, WellDyneRx Customer Service, VSP Customer Service or Multnomah County Benefits Office if they have any questions.
b. Treat all providers and their staff with courtesy and respect.
c. Be on time for appointments and call the office ahead of time if they will be late or need to cancel their appointment.
d. Get regular health checkups and preventive services.
e. Give their provider all the information needed for him or her to provide good healthcare.
f. Participate in making decisions about their medical care and forming a treatment plan.
g. Follow plans and instructions for care they have agreed to with their provider.
h. Use urgent and emergency services appropriately.
i. Show their medical ID (identification) card when seeking medical care.
j. Tell providers about any other insurance policies that may provide coverage.
k. Reimburse the Group from any third party payments they may receive according to section 10.4.2.
l. Provide information the Plan needs to properly administer benefits and resolve any issues or concerns that may arise.

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

2. What if a Member has a medical emergency?

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

3. If a Member not satisfied with the Plan, how can an appeal or complaint be filed?

A member can file an appeal or complaint related to the medical benefits by writing a letter to Moda Health (P.O. Box 40384, Portland, Oregon 97240). Customer Service can help the member 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 8.11.8 for info related to vision care appeals). Complete information can be found in section 10.2.

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 400
Portland, OR 97214
Telephone: 503-988-3477
FAX: 503-988-6257
Email: employee.benefits@multco.us

4. What are the prior authorization and utilization review criteria?

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

Obtaining prior authorization is the member's assurance that medical services won't be denied because they don't meet the Plan's definition of "medical necessity." Except in the case of fraud or misrepresentation, prior authorization for benefit coverage and medical necessity shall be binding if obtained no more than 30 days prior to the date the service is provided, and eligibility shall be binding for 5 business days from the date of the authorization.

Utilization review is a 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. The definition of "Medically Necessary" is explained in Section 5.

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

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

The Plan protects members' information in several ways:

a. There is a written policy to protect the confidentiality of health information.

b. Only employees who need to access member information in order to perform their job functions are allowed to do so.
c. Disclosure outside the Plan or 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.

6. How can a Member participate in the development of Moda Health's corporate policies and practices?

Member feedback is very important to Moda Health. Moda Health welcomes any suggestions for improvements to the Plan or Moda Health's services.

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

7. How can non-English speaking Members get information about the Plan?

Customer Service will coordinate the services of an interpreter over the phone when a member calls. Also see the nondiscrimination notice on the following page. For vision care, members can access language interpreter services at no cost by calling VSP Member Services at 800-877-7195.

Nondiscrimination notice

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

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

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

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

888-217-2363 (TDD/TTY 711)

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

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

Dave Nesseler-Cass coordinates our nondiscrimination work:

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

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.

Dental plans in Oregon provided by Oregon Dental Service, dba Delta Dental Plan of Oregon. Dental plans in Alaska provided by Delta Dental of Alaska. Health plans provided by Moda Health Plan, Inc. Individual medical plans in Alaska provided by Moda Assurance Company. 39969758 (9/19)

moda HEALTH

DELTA DENTAL

Delta Dental of Oregon & Alaska

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

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

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

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

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

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

بولتے ہیں تو لسانی (URDU) توجہ دیں: اگر آپ اردو 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)

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DELTA DENTAL

Delta Dental of Oregon & Alaska

39969758 (9/19)

For help, call us directly at 888-445-7413
(En Español: 888-786-7461)

P.O. Box 40384
Portland, OR 97240

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