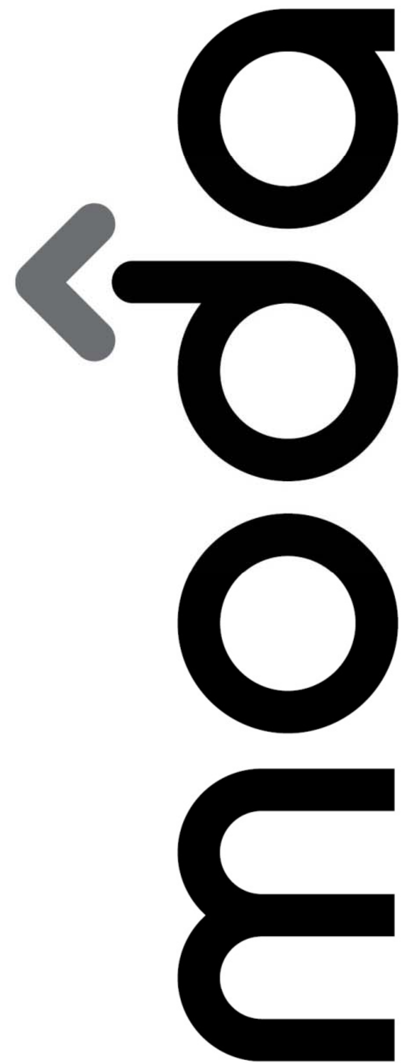
Preferred PPO Plan

Effective date: January 1, 2014

Classes 0003, 0006, 0008, 0009, and 0010



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SECTION 1. WELCOME

This handbook describes the main features of the medical plan (the "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 claims and other administrative services.

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

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

This handbook may be changed or replaced at any time, by 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 plan provisions are governed by the Group's agreement with Moda Health. This handbook may not contain every plan provision.

1.1 MEMBER RESOURCES

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

Moda Health's Medical Customer Service Department
Portland 503-265-2964, Toll-Free 1-888-445-7413
En Español 503-265-2961, Llamado Gratis 1-888-786-7461

Moda Health's Pharmacy Customer Service Department
Toll-Free 1-800-913-4284

Moda Health Behavioral Health
Portland 503-624-9382, Toll-free 1-800-799-9391

Telecommunications Relay Service for the hearing impaired
711

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

SECTION 2. GENERAL PLAN INFORMATION

1. **Funding Medium and Type of Plan Administration:** The Plan is self-funded and the Group has contracted with Moda Health to provide claims and other administrative services.

   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.

2. **Grandfathered Plan Disclosure**: The Group believes the Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any Cost Sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at:

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

Members may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

SECTION 3. SUMMARY OF BENEFITS – A QUICK REFERENCE

This section is a quick reference summarizing the Plan's benefits. The details of the actual benefits and the conditions, limitations and exclusions of the Plan are contained in the sections that follow. **Benefits are paid based on a PLAN YEAR – January through December.**

Section 6 provides information regarding prior authorization requirements. Members can access a complete list of procedures that require prior authorization on myModa or by contacting Customer Service. Failure to obtain required prior authorizations will result in denial of benefits or a penalty.

3.1 NETWORK INFORMATION

Provider Networks
ODS Plus Network
Pharmacy network is Northwest Prescription Drug Consortium (NPDC)

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

3.1.1 Primary Network; Primary Service Area

All members will 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.

3.2 SCHEDULE OF BENEFITS FOR MEDICAL BENEFITS

PLAN DESIGN	In-Network Benefits	Out-Of-Network Benefits
Annual Deductible per Member	**$400**	
Maximum Annual Family Aggregate Deductible	**$800**	
Annual Medical Out-of-Pocket Maximum per Member (does not include deductible or prescription out of pocket costs)	**$2,000**	
Annual Medical Out-of-Pocket Maximum per Family (does not include deductible or prescription out of pocket costs)	**$6,000**	

BENEFITS	COPAYMENT/COINSURANCE (Amount Member Pays) In-Network	Out-Of-Network	DETAILS
Ambulance Transport			
Ambulance Transportation	20%	20%	Page 25
Ambulatory Services			
Ambulatory Surgery and Invasive Diagnostic Procedures (Facility Charges)	20%	40%	Page 25
Chemical Dependency Services – Outpatient Program	20%	40%	Page 26
Diagnostic X-ray and Lab	20%	40%	Page 26
Imaging Procedures	20%	40%	Page 26
Infusion Therapy			Page 26
Home Infusion	20%	40%	
Outpatient Infusion	20%	40%	
Kidney Dialysis	20%	40%	Page 27
Outpatient Rehabilitation	20%	40%	Page 27 - 60 sessions per plan year.
Therapeutic X-ray	20%	40%	Page 27
Emergency Care			
Emergency Room Facility	$75 per visit, then 20%	$75 per visit, then 20%	Page 28 Copay waived if covered hospitalization immediately follows emergency room use.
Hospice Care			Page 29
Home Care	No Cost Sharing	40%	
Inpatient Care	No Cost Sharing	40%	12 days
Respite Care	No Cost Sharing	40%	170 hours
Hospital Care and Residential Facility Care			
Chemical Dependency Detoxification	20%	40%	Page 31
Inpatient Acute Care	20%	40%	Page 31
Inpatient Rehabilitation	20%	40%	Page 31 - Confinement must begin within one year of onset of the condition
Residential Mental Health & Chemical Dependency Treatment Programs	20%	40%	Page 31
Skilled Nursing Facility Care	20%	40%	Page 31 – 100 days per plan year

BENEFITS	COPAYMENT/COINSURANCE (Amount Member Pays)		DETAILS
	In-Network	Out-Of-Network	
Medications			
Prescription Drugs			Page 44
Retail Pharmacy			Up to 30-day supply or 100 pills per prescription
Tier 1 Select Generic	20%, $50 maximum	20%, $50 maximum	
Tier 2 Preferred	20%, $50 maximum	20%, $50 maximum	
Tier 3 Non-Preferred	50%	50%	
Tier 3 Non-Formulary	50%	50%	
Mail Order Pharmacy			90-day supply per prescription
Tier 1 Select Generic	20%, $35 maximum	N/A	
Tier 2 Preferred	20%, $150 maximum	N/A	
Tier 3 Non-Preferred	50%	N/A	
Tier 3 Non-Formulary	50%	N/A	
Specialty Pharmacy			Up to 30-day supply or 100 pills per prescription
Tier 1 Select Generic	20%, $50 maximum	N/A	
Tier 2 Preferred	20%, $50 maximum	N/A	
Tier 3 Non-Preferred	50%	N/A	
Tier 3 Non-Formulary	50%	N/a	
Professional Services			
Acupuncture Care	20%	40%	Page 32 - 20 visits per plan year
Alternative Care	50% (deductible waived)	50% (deductible waived)	Page 32 - $300 aggregate plan year maximum and can use in-network or out-of-network providers
Annual GYN Exam & Pap Tests including routine mammogram	$15 copay, deductible waived	40%	Page 29
Dental Care (treatment following dental accident only)	20%	40%	Page 34

BENEFITS	COPAYMENT/COINSURANCE (Amount Member Pays)		DETAILS
	In-Network	Out-Of-Network	
Diabetes Self-Management Programs	No copay (deductible waived)	No copay (deductible waived)	Page 34 - Once, following diagnosis
Hearing Aids and Related Services (Mandated Benefits for Enrolled Children up to age 26)	20%	20%	Page 35 - Once every 48 months
Home and Office Visits	20%	40%	Page 35
Mental Health Services – Outpatient	20%	40%	Page 36
Physician Hospital Visits	20%	40%	Page 35
Routine Physical Exams	20%, deductible waived	40%, deductible waived	Page 37 - One per plan year, age 2+
Routine Diagnostic X-ray & Lab	20%, deductible waived	40%, deductible waived	Page 37
Immunizations	20%, deductible waived	40%, deductible waived	Page 37
Prostate Rectal Exam	20%, deductible waived	40%, deductible waived	Page 38 - One per plan year, age 50+
Prostate Specific Antigen (PSA) Test	20%, deductible waived	40%, deductible waived	Page 38 - One per plan year, age 50+
Routine Colonoscopy	20%, deductible waived	40%, deductible waived	Page 37 -One per 10 plan years, age 50+.
Surgery	20%	40%	Page 38
Temporomandibular Joint Syndrome	20%	40%	Page 38 - $1,500 lifetime maximum
Therapeutic Injections	20%	40%	Page 39
Tobacco Cessation Treatment			Page 39 – age 15+
Consultation	No Cost Sharing	No Cost Sharing	
Supplies	No Cost Sharing	No Cost Sharing	
Prescription Drugs	No Cost Sharing	No Cost Sharing	Prescriptions may be purchased at any participating pharmacy.
Urgent Care Visits	20%	40%	Page 35
Well-Baby Exams	20%, deductible waived	40%, deductible waived	Page 39
Other Services			
Biofeedback	20%	40%	Page 39 up to 10 lifetime visits
Disposable Supplies (provided in a physician's office)	20%	40%	Page 41
Durable Medical Equipment - Outpatient	20%	40%	Page 41

BENEFITS	COPAYMENT/COINSURANCE (Amount Member Pays) In-Network	Out-Of-Network	DETAILS
Home Healthcare & Skilled Nursing Care	20%	40%	Page 39 Requires authorization. 60 visits per plan year
Maternity	Treated same as any other condition.	Treated same as any other condition.	Page 40
Supplies and Appliances	20%	40%	Page 41
Transplants			Page 42
Exclusive transplant network facility	20%	N/A	
Other facilities	Not covered	Not covered	
Donor Costs			
Exclusive transplant network facility	20%	N/A	
Other facilities	Not covered	Not covered	

3.3 Summary of Benefits

3.3.1 Medical Deductible

Each Member $400
Total family $800

3.3.2 Percentage The Plan Pays For Covered Expenses After The Deductible

In-Network Benefits	After the deductible, the Plan pays 80% of contracted fees for eligible services.
Out-of-Network Benefits	After the deductible, the Plan pays 60% of Maximum Plan Allowance for eligible services.
Out-of-Network Benefits when In-Network Panel does not include any such providers	After the deductible, the Plan pays 60% of Maximum Plan Allowance for eligible services.
Living or traveling outside the In-Network Service Area	After the deductible, the Plan pays 60% of Maximum Plan Allowance for eligible services.

3.3.3 Medical Out-Of-Pocket Maximum

Each Member per year $2,000
Total family per year $6,000

After a Member or family reaches the annual medical out-of-pocket maximum, the Plan will pay 100% of Maximum Plan Allowance (contracted fees if rendered by In-Network Providers) for Covered Services incurred during the remainder of that year for that Member. Annual deductible, non-covered expenses, and prescription drug out-of-pocket expenses do not accumulate toward this medical maximum.

3.3.4 Prescription Out-Of-Pocket Maximum

Each Member per year .... $2,000 for select generic, preferred, and non-formulary drugs

After a Member reaches the annual prescription out-of-pocket maximum, the prescription plan will pay 100% of the covered expense for select generic, preferred, and non-formulary drugs (based upon the Moda Health Preferred Drug List) for Rx purchases made at participating In-Network pharmacies for the Member for the remainder of that year. The Plan's medical out-of-pocket expenses, the medical plan deductible, and medical non-covered expenses do not accumulate toward this prescription maximum.

3.3.5 Overview Of Covered Expenses

a. Ambulance
To the nearest facility that has the capability to provide the necessary treatment (see section 8.1)

b. Chemical Dependency Detoxification Program
All-inclusive per diem charge for room and treatment services by a program that meets the definitions in the Plan (see section 8.5.1).

c. Chemical Dependency Outpatient Treatment Program
Assessment and treatment services by a treatment program that meets the definitions in the Plan (see section 8.2.3).

d. Diabetes Self-Management - Deductible Waived
One diabetes self-management program which the Member has been certified as having successfully completed (see section 8.6.6 for Limitations).

e. Hospice
Specified services and supplies provided by an Approved Hospice for care of the terminally ill (see section 8.4 for Benefits and Limitations.)

f. Hospital - Inpatient Care (see section 8.4)

i. Daily hospital room allowance will not exceed the average daily semi-private rate of the hospital.
ii. Other Medically Necessary hospital services.

Type of Care	Maximum number of days per year
Medical/surgical	unlimited
Rehabilitative	unlimited
Intensive Care Unit	unlimited

g. Hospital - Outpatient Care

i. Emergency room treatment (special deductible applied, see section 8.3)
ii. Outpatient Surgery
iii. Pre-admission testing

h. Mammograms/Pap Tests - Deductible Waived
Professional Provider charges and related lab charges (see section 8.6.3 for Limitations.)

i. **Maternity**
Medically Necessary services and supplies (see section 8.7.3).

j. **Professional Providers**
Medically Necessary services of a Professional Provider who meets the definitions in the Plan (see section 8.6).

k. **Residential Mental Health & Chemical Dependency Treatment Program**
All-inclusive per diem charge for room, (if overnight program), and treatment services by a treatment program that meets the definitions in the Plan (see section 8.5.5).

l. **Routine Physicals - Deductible Waived**
Routine physical examinations, related x-ray and lab, and immunization charges for Members (see section 8.6.18 for Limitations.)

m. **Skilled Nursing Facility**
Daily room allowance, but not more than the semi-private room rate nor more than 100 days per Plan Year, plus other Medically Necessary services (see section 8.6.3).

n. **Special Facility**
Procedure room plus other Medically Necessary services and supplies (see section 8.2).

o. **Supplies and Appliances**
Medically Necessary items which relate directly to the treatment of a Medical Condition (see section 8.7.5).

p. **Well Baby Care - Deductible Waived**
Professional Provider charges for routine examinations of an Enrolled child (see section 8.6.24 for Limitations.)

SECTION 4. DESCRIPTION OF BENEFITS

A complete description of the covered expenses and an explanation of how the Plan pays is given in the following sections.

4.1 MEMBERSHIP CARD

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

Members may go to myModa or contact Customer Service for replacement of a lost identification card.

4.2 WHEN BENEFITS ARE AVAILABLE

The Plan only pays claims for Covered Services obtained when a Member's coverage is in effect. Coverage is in effect when the Member:

a. Is eligible to be covered according to the eligibility provisions of the Plan
b. Has applied for coverage and has been accepted
c. Has 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.

The expense of a service is incurred on the day the service is rendered and the expense of a supply is incurred on the day the supply is delivered to the Member.

4.3 DEDUCTIBLES

The Plan has an annual deductible effective January 1st through December 31 each year. The amount of the medical deductible is shown in section 3.4.1. 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 3.4.1, 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. Expenses applied towards the Plan Year medical deductible do not apply to the Plan Year medical out-of-pocket maximum.

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 the Plan replaces a group policy of the Group during a Plan Year, any medical deductible amount satisfied under the 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.

4.4 BENEFIT PAYMENT

Once the medical deductible is satisfied, the Plan will pay a percentage of the covered expenses described below.

The Plan will pay a percentage of covered expenses:

Out of Network Providers: 60%(*) of Maximum Plan Allowance, or
In Network Providers: 80% of contracted fees

The remaining 40% for Out of Network Providers or 20% 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.

Once each Member's medical out-of-pocket expenses accumulate to the $2,000 annual medical out-of-pocket maximum (which does not include the medical or prescription drug deductible, prescription drug Copays, the Emergency Room Copay, the out-of-pocket expenses for transplants not performed at an exclusive transplant network facility, the out-of-pocket expenses for Alternative Care, and/or 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 out-of-pocket maximum for the family is $6,000.

- * 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 60% of Maximum Plan Allowance of covered expenses after the deductible. The amount which the Member must pay is the remaining 40%, expenses applied to the deductible, and the any portion of the charge in excess of Maximum Plan Allowance.

- * For Members living or traveling outside the In-Network Service Area, payment will be 60% of Maximum Plan Allowance of covered expenses after the deductible. The amount which the Member must pay is the remaining 40%, expenses applied to the deductible, and any portion of the charge in excess of Maximum Plan Allowance.

4.5 PAYMENT OF EXPENSES

The amount of covered 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 Copayments, Coinsurance, deductibles, and plan benefit limitations, In-Network Providers agree to look solely to the Plan, if the Plan is paying In-Network Provider, for compensation of Covered Services provided to Members. Nothing in this paragraph shall prohibit a Provider and a Member from entering into an agreement for payment by the Member for medical services that are not covered by the Plan.

4.6 MEDICARE

Expenses covered by Medicare (Parts A and B) are subject to Coordination of Benefits (see sections 10.5 and 0 for details). Payable medical benefits under the Plan will be paid based upon an estimate of the Medicare benefit 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.

4.8 CARE AFTER NORMAL OFFICE HOURS

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

SECTION 5. DEFINITIONS

The following are definitions of some important terms used in this handbook. Some other terms are defined where they are used.

Affidavit of Marriage or Domestic Partnership means a signed document that attests the Subscriber and one other eligible person have a specific and recognized relationship. Document is required by the Group from every employee who seeks to Enroll a spouse or Domestic Partner for health plan coverage.

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

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

Authorization see Prior Authorization.

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

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

Claim Determination Period means 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 of the Plan.

Creditable Coverage means a Member's prior healthcare coverage including coverage remaining in force at the time a Member obtains new coverage, under any of the following:

a. A Group Health Plan
b. Individual Insurance coverage including student health plans
c. Medicare Part A and B
d. Medicaid, other than benefits consisting solely of benefits under Section 1928 (pediatric vaccines)
e. Tricare
f. A medical care program of the Indian Health Service or of a tribal organization

g. A State high risk pool
h. Federal Employees Health Benefit Plan (FEHBP)
i. A public health plan (as defined in regulations)
j. A State Children's Health Insurance Program (S-CHIP)
k. A health benefits plan under section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e))

Some plans that provide medical care coverage do not qualify as Creditable Coverage. Such plans are called excepted benefits. The following plans are excepted benefits:

a. Coverage only for accident, or disability income insurance, or any combination thereof
b. Coverage issued as a supplement to liability insurance
c. Liability insurance, including general liability insurance and automobile liability insurance
d. Worker's Compensation or similar insurance
e. Automobile medical payment insurance
f. Credit-only insurance
g. Coverage for on-site medical clinics
h. Other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance

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

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

Dental Accident means an accidental Injury to natural teeth (see section 8.6.5 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 rendered to repair defects which have developed because of tooth loss and services or supplies rendered to restore the ability to chew. All expenses related to installation of dental implant are considered only under the dental plan (see section 8.6.5 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 following criteria:
The Domestic Partner and Subscriber
   i. Are at least 18 years of age; and
   ii. Have jointly shared the same regular and permanent residence for at least 6 months; or registered as Domestic Partners through the Multnomah County Domestic Partner Registry and
   iii. Are not married to anyone and have not had a spouse, or another Domestic Partner within the prior 6 months. If previously married, the 6-month period starts on the final date of divorce. If previously united in a State Registered Domestic Partnership, the 6-month period starts on the final date State Registered Domestic Partnership is terminated by the court. If previously involved in a non stated registered Domestic Partnership, the 6-month period starts when the prior partnership dissolved and partners were no longer sharing the same residence; and
   iv. Share a close personal relationship and are not related by blood closer than would bar marriage in the state of Oregon; and
   v. Were mentally competent to contract when their domestic partnership began;
   vi. Are responsible for each other's welfare and are jointly financially responsible for basic living expenses defined as the cost of food, shelter and any other expenses of maintaining a household. Financial information must be provided if requested; and
   vii. Are each other's sole Domestic Partner.

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:

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. and meets the eligibility requirements specified in section 13.1.1 or 13.1.2

Emergency Medical Condition means a Medical Condition that manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson possessing an average knowledge of health and medicine 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, Ancillary tests and medical determinations required to ascertain the nature and extent of an Emergency Medical Condition.

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

Enroll means to become covered for benefits under the Plan (that is, when coverage becomes effective) without regard to when the person may have completed or filed any forms that are required in order to become covered. For this purpose, a person who has health coverage is enrolled in the Plan regardless of whether the person elects coverage, the person is a Dependent who becomes covered as a result of an election by a Subscriber, or the person becomes covered without an election. Please see Enrollment Section beginning on page 86 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 application has been accepted.

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

Experimental or Investigational means services and supplies that:

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

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

The **Group** is Multnomah County, that has contracted with Moda Health to provide 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 a 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.

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

Implant means a material inserted into the body 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. Injury does not include damage caused by routine or normal body movements such as stooping, twisting, bending or chewing and does not include any condition related to pregnancy.

In-Network refers to Providers such as hospitals, Professional Providers, Chemical Dependency treatment programs and facilities that have contracted with Moda Health to provide care to Members covered under the Plan.

Maximum Plan Allowance (MPA) is the maximum amount that the Plan will reimburse an Out of Network Providers. For an In-Network Provider, the MPA is the amount the Provider has agreed to accept for a particular service.

Moda Health will process charges by an Out-of-Network Provider as follows: the maximum amount 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 implanted medical devices is the contracted amount, or the acquisition cost of the device plus 10% if there is no contracted amount.

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

When using an Out-of-Network Provider, any amount above the MPA is the Member's responsibility.

Medical Condition means any physical or mental Condition including but not limited to 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 those services and supplies that are required for diagnosis or treatment of a Medical Condition and are:

a. Appropriate and consistent with the symptoms or diagnosis of the Member's Condition
b. Established as the standard treatment by the medical community in the Service Area in which they are received

c. Not primarily for the convenience of the Member or a Provider
d. The least costly of the alternative supplies or levels of service which can be safely provided to the Member. For example, care rendered in a hospital inpatient setting is not Medically Necessary if it could have been provided in a less expensive setting, such as a Skilled Nursing Facility or by a nurse in the Member's home without harm to the Member

Medically Necessary care does not include Custodial Care (see the definition of Custodial Care).

Please Note:
The fact that a Provider prescribes, orders, recommends, or approves a service or supply does not, of itself, make the service Medically Necessary or a covered expense. More information regarding medical necessity is in General Exclusions (Section 9).

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

Member means a Subscriber, Dependent of a Subscriber or a person otherwise eligible for a Group Health Benefit Plan who has 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 Illness, as defined in the Plan.

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

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

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

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

Moda Health Behavioral Health provides specialty services for managing Mental Health and Chemical Dependency benefits to help Members access care in the right place, while helping the Group to contain costs.

Network means a group of Providers who contract to provide healthcare to Members. Such groups are called Preferred Provider Organizations (PPOs), and provide In-Network services in their specific service areas. Covered medical expenses will be paid at a higher rate when an in-network provider is used (see section 3.3).

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

Out-of-Network refers to Providers such as Professional Providers, Chemical Dependency treatment programs and facilities that have not contracted under Moda Health to provide benefits to Members. They will be reimbursed based on the Maximum Plan Allowance for the service provided.

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

Partial Hospitalization or **Day Treatment** means an appropriately licensed Mental Health or Chemical Dependency facility providing no less than 4 hours of direct, structured treatment services per day.

Payment of Expenses refer to expenses which are allowed by the Plan and are paid 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 Allowances are established, reviewed, and updated by a national database.

Penalty payments are required in some instances if a Member fails to comply with Plan requirements. See Cost Containment Section (section 6) for a specific explanation of the applicable Penalty for failure to comply with: Inpatient Hospitalization Prior Authorization (section 6.1.1), Ambulatory Surgery Prior Authorization (section 6.1.2), Outpatient Services Prior Authorization (section 6.1.2), and Mandatory Second Surgical Opinion (section 6.2).

The **Plan** is the Health Benefit Plan sponsored and funded by the Group and Moda Health is contracted to provide its claims and other administrative services for medical and vision 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 for prescription drug 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 prior to the date of service. A complete list of services and drugs that require prior authorization is available on myModa or by contacting Customer Service. Failure to obtain required authorization may result in denial of benefits or a penalty (see Section 6 for medical authorization and section 8.9.8 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 license. In all cases, the services must be covered under the Plan to be eligible for benefits. Examples of professional providers include:

a. Acupuncturist
b. Chiropractor
c. Dentist (doctor of medical dentistry or doctor of dental surgery), but only for treatment of accidental Injury to natural teeth provided within 12 months after the Injury, or for surgery that does not involve repair, removal or replacement of teeth, gums, or supporting tissue;
d. Hearing aid specialist
e. Naturopath
f. Optometrist
g. Physician (doctor of medicine or osteopathy)
h. Podiatrist
i. Registered nurse first assistant
j. Registered physical, occupational, or speech therapist, but only for rehabilitative services provided upon the written referral of a physician
k. Audiologist
l. State-licensed massage therapist
m. A Mental Health Provider as defined above
n. Nurse (nurse practitioner, including a certified nurse midwife and a registered nurse or licensed practical nurse providing services upon the written referral of a physician and for which nurses customarily bill patients
o. Physician assistant
p. A tobacco cessation program following the United States Public Health guidelines for tobacco use cessation

The term "Professional Provider" does not include any class of provider not named above, unless otherwise stated, and no benefits of the Plan will be paid for their services.

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 but not limited to a facility, a medical supplier, a program or a Professional Provider, that is state licensed and approved to provide covered service or supply to a Member. The term "Provider" does not include any class of Provider not named, and no benefits of the Plan will be paid for their services unless otherwise stated.

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 included programs for treatment of mental illness or chemical dependency. Residential Program does not include any program that provides less than four hours per day of direct treatment services.

Service Area is the geographical area where the In-Network Providers provide their services.

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

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

SECTION 6. COST CONTAINMENT

The Plan contains the following cost containment provisions that may affect how benefits are paid.

Possible Penalties
Benefits will be reduced $100.00 if a Member does not obtain Prior Authorization for inpatient, residential, Day Treatment, or Partial Hospitalization stays, Continued Stay, and 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

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 members 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 Member may obtain Authorization information by contacting Moda Health Customer Service, or for mental health or chemical dependency services by contacting Moda Health Behavioral Health.

6.1.1 Inpatient Services and Residential Programs

Prior Authorization is required for all non-emergency hospital confinements that are scheduled in advance, and admission to any residential treatment program in order for maximum plan benefits to be payable. If 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 emergency hospital admission (or as soon as reasonably possible).

6.1.2 Ambulatory Surgery and Other Outpatient Services

The Plan requires prior authorization for many outpatient services. 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. Some 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. For Members utilizing all networks other than Private HealthCare Systems (PHCS), if authorization is not obtained ***in advance*** of receiving such services, the charges will be denied.

In-Network Providers who perform the 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*.**

6.2 MANDATORY SECOND SURGICAL OPINION (COMPLIANCE FAILURE SUBJECT TO FINANCIAL PENALTY)

Moda Health may require an independent consultation to confirm that non-emergency surgery 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.

Penalty
If a Member chooses not to participate in the mandatory second surgical opinion program or decides to have surgery when it is not recommended by the consulting surgeon, benefits payable will be reduced $100.00. The $100.00 Penalty does not apply towards the Plan's deductible or the out-of-pocket maximum.

6.3 BENEFIT EXCEPTIONS FOR COST EFFECTIVENESS SERVICES

Unique and unusual circumstances may create situations where a Member seeks coverage for medically necessary care not otherwise covered by the Plan. When doing so is cost effective, and medically appropriate as determined by Moda Health's medical director in conjunction with a treatment plan authorized by the Member's attending Professional Provider, Moda Health will contact the Group with the proposal and make a recommendation on whether a benefit exception to provide coverage for the medically necessary services is appropriate.

Payment of benefits for services not otherwise covered by the Plan (benefit exceptions) 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 provided a benefit exception for a Member shall not obligate the Plan to pay such benefits for any other Member, nor shall it obligate the Plan to pay for continued or additional benefit exceptions for the same Member. All amounts paid for benefit exceptions under this provision shall be included in computing any benefits, limitations, Copayments or Coinsurance under the Plan.

SECTION 7. 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.

This 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.

7.1 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 their Professional Provider and improve their health status, quality of life and productivity.

IF CALLING FROM PORTLAND AREA 503-265-2964
OUTSIDE THE PORTLAND AREA 1-888-447-7413

Case Management Office Hours - Monday through Friday
9:00 am to 4:30 pm (Pacific Time).

SECTION 8. COVERED EXPENSES

The Plan covers services and supplies listed when Medically Necessary for diagnosis and/or treatment of a Medical Condition. Payment of covered expenses is always limited to the Maximum Plan Allowance for the Provider. Expenses are subject to the deductible unless specifically listed as not subject to deductible and applicable Coinsurance or Copay. Some benefits have day or dollar limits. These limits are found in the "Details" column in the Schedule of Benefits (see section 3.3).

Many services require Prior Authorization. A complete list is available on myModa or by contacting Customer Service. **Failure to obtain required Prior Authorizations may result in denial of benefits or payment at the Out-of-Network benefit level** (see Section 6)**.**

8.1 AMBULANCE TRANSPORTATION

Local ground transportation by state certified ambulance is covered for Medically Necessary transport to the nearest facility that has the capability to provide the necessary treatment.

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. If air ambulance crosses water, the benefit is limited to the reimbursement rate of a ground ambulance.

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

8.2 AMBULATORY SERVICES

Many outpatient/ambulatory services require Prior Authorization. A complete list is available on myModa or by contacting Customer Service. **Failure to obtain required Prior Authorization can result in denial of benefits or payment at the Out-of-Network benefit level.**

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.

8.2.1 Ambulatory 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 6.1.2).

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.

8.2.2 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.

8.2.3 Chemical Dependency Services – Outpatient Program

Services for assessment and treatment of Chemical Dependency in an outpatient treatment program that meets the definitions in the Plan are covered, subject to medical necessity.

Moda Health Behavioral Health can help Members locate In-Network Providers and understand their Chemical Dependency benefits.

8.2.4 Diagnostic X-rays and Laboratory Tests

The Plan covers diagnostic x-rays and laboratory tests ordered by a Professional Provider within the scope of his or her license. The x-rays or tests must be related to the treatment of a Medical Condition.

8.2.5 Imaging Procedures

The Plan covers all standard imaging procedures related to treatment of a Medical Condition. The following advanced imaging services require Prior Authorization:

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

8.2.6 Infusion Therapy

Covered expenses include fees for 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 Customer Service before receiving such care.

Home infusion therapy must be provided by an accredited home infusion therapy agency. In addition, Members receiving the services must qualify as being ‘homebound’ (as defined in section 8.7.2.)

Infusion therapy benefits are limited to the following:

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

In addition, covered expenses include only the following Medically Necessary services and supplies:

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

8.2.7 Radium, Radioisotopic, X-ray Therapy, and Kidney Dialysis
Covered expenses include:

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

8.2.8 Rehabilitation – 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.**

Rehabilitative services are physical, occupational, or speech therapies 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.

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. Services related to treatment, testing or training for learning disabilities
f. Testing or treatment for mental retardation for Members age 18 or older
g. Hippotherapy

8.2.9 Routine Costs in Clinical Trial
Routine costs for the care of a Member who is enrolled in or participating in qualifying clinical trials are covered. Routine costs mean Medically Necessary conventional care, items or services covered by the Plan if typically provided absent a clinical trial. Such costs will be subject to the

applicable Cost Sharing if provided in the absence of a clinical trial. Neither the Plan nor Moda Health is liable for expenses related to any adverse effects of the clinical trials.

Qualified clinical trials are limited to those:

a. Funded or supported by a center or cooperative group that is funded by the National Institutes of Health, the Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, the Centers for Medicare and Medicaid Services, the United States Department of Energy, the United States Department of Defense or the United States Department of 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

The Plan does not cover:

a. The drug, device or service being tested in the clinical trial unless the drug, device or service would be covered by the Plan if provided outside of a clinical trial
b. Items or services required solely for the provision of the drug device or service being tested in the clinical trial
c. Items or services required solely for the clinically appropriate monitoring of the drug, device or service being tested in the clinical trial
d. Items or services required solely for the prevention, diagnosis or treatment of complications arising from the provision of the drug, device or service being tested in the clinical trial
e. Items or services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the Member
f. Items or services customarily provided by a clinical trial sponsor free of charge to any person participating in the clinical trial
g. Items or services that are not covered by the Plan if provided outside of the clinical trial

8.3 EMERGENCY CARE ($75 COPAYMENT)

Members are covered for treatment of Emergency Medical Conditions worldwide. A member who believes he or she has a medical emergency should call 9-1-1 or seek care from the nearest appropriate provider, such as a physician's office or clinic, urgent care facility or emergency room. All Emergency Room Services rendered by Out-of-Network Providers will be reimbursed at the In-Network benefit level. However, benefits are subject to the contracted rates for In-Network Providers and the Maximum Plan Allowance for Out-of-Network Providers. The emergency room facility Copayment applies to services billed by the facility. Professional fees (e.g., emergency room Physician, or x-ray/lab) billed separately are subject to the appropriate benefit level. 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 $75 Emergency Care Copayment does not help satisfy the medical deductible or medical out of pocket maximum.

Prior Authorization is not required for Emergency Medical Screening Exams or treatment to stabilize an Emergency Medical Condition. Prior Authorization is also not required for Emergency Services provided by an Out-of-Network Provider when a prudent layperson possessing an average knowledge of health and medicine would reasonably believe that the

time required to go to an In-Network Provider would place the health of the Member, or a fetus in the case of a pregnant woman, in serious jeopardy.

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 Member's 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 to an In-Network facility.

The In-Network benefit level will not be available for an Out-of-Network Provider for care other than emergency medical care. The following are not Emergency Medical Conditions and are not eligible for In-Network benefit level (this list is not inclusive of all such services):

a. Preventive services
b. Diagnostic work-ups for chronic Conditions
c. Elective surgery and/or hospitalization unless Authorized as services not readily accessible from In-Network providers

8.4 Hospice Care

8.4.1 Definitions

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

Home Health Aide means an employee of an Approved Hospice who provides intermittent, Custodial Care under the supervision of a registered nurse, physical therapist, occupational therapist or speech therapist.

Hospice Treatment Plan means a written plan of care established and periodically reviewed by the Member's attending Physician. The Physician must certify in the treatment plan that the Member is terminally ill and the treatment plan must describe the services and supplies for Medically Necessary or palliative care to be provided by the Approved Hospice. The Hospice Treatment Plan should be submitted to Moda Health for Prior Authorization. Failure to obtain required Prior Authorization may result in denial of benefits or payment at the Out-of-Network benefit level.

The Plan will waive any required deductible and provide benefits for the services and supplies listed below when they are included in a Hospice Treatment Plan. Services must be provided and billed by an Approved Hospice agency to a Member who is terminally ill and not seeking further curative treatment.

8.4.2 Hospice Home Care

The Plan will pay 100% of covered charges for 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 for up to twelve days during the period of covered hospice care.

8.4.4 Respite Care

Respite Care means care for a period of time to relieve persons residing with and caring for a Member in hospice from their duties. Respite care is not a benefit available to allow the caregiver to return to work.

The Plan will pay 100% of covered charges for respite care provided to a Member who requires continuous attendance when arranged by the attending Professional Provider and Prior Authorized. Benefits are limited to 120 hours of Respite Care per 3 month period of covered Hospice Care for services provided in what Moda Health determines is the most appropriate setting.

The services and charges of a non-Professional Provider may be covered for Respite Care if approval is given by Moda Health in advance.

8.4.5 Exclusions – Specific to Hospice Care

In addition to exclusions listed in section 9, the following hospice services 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 set forth as a Hospice benefit
c. Services and supplies in excess of the stated limitations

8.5 HOSPITAL & RESIDENTIAL FACILITY CARE

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

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

Hospitalization must be directed by a Physician and must be Medically Necessary for acute care and treatment of a Medical Condition.

Inpatient stays require Prior Authorization (see section 6.1.1).

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 per diem charge for room and treatment services by a treatment program that meets the definitions in the Plan, subject to medical necessity.

8.5.2 Hospital Benefits

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

a. **Hospital room**, the actual daily charge, not to exceed the hospital's most common rate for a 2-bed room
b. **Isolation care**, when the Plan agrees it is necessary to protect other patients from contagion or to protect a Member from contracting the Illness of another person
c. **Intensive care unit.** Using generally recognized industry standards as a guide, the Plan reserves the right to decide whether a unit in a particular hospital qualifies as an intensive care unit
d. **Facility charges** for surgery performed in a hospital outpatient department
e. **Other hospital services and supplies** (including prescription drugs dispensed while patient is hospitalized) that are necessary for treatment and are ordinarily furnished by a hospital. These include, but are not limited to, operating and recovery room, and traction equipment

Coverage for take-home prescription drugs following a period of hospitalization will be limited to a **3-day supply, issued by the hospital,** at the same benefit level as for hospitalization. (Refer to section 8.9 for the retail and/or mail order prescription drug coverage).

All inpatient stays require Prior Authorization. See section 6 for additional information.

8.5.3 Inpatient Rehabilitative Care

Covered expenses include rehabilitative care for an inpatient in a hospital or other inpatient rehabilitation facility that specializes in providing 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.

In order to be a covered expense, rehabilitative services must begin within one year of the onset of the Condition from which the need for services arises and must be a medically necessary part of a Physician's formal written program to improve and restore lost function following an Illness or Injury.

8.5.4 Pre-admission Testing

Medically Necessary pre-admission testing is covered when ordered by the Physician.

8.5.5 Residential Mental Health and Chemical Dependency Treatment Programs

All inclusive per diem charge for room and treatment services, including day treatment and partial hospitalization, by a treatment program that meets the definitions in this Plan, are covered, subject to medical necessity.

8.5.6 Skilled Nursing Facility Benefits

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

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 deficiency or retardation in Members age 18 or older
d. Mental Illness

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

8.6 PROFESSIONAL PROVIDER SERVICES

Medically Necessary services of Professional Providers are covered under the Plan.

8.6.1 Acupuncture

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 of a licensed acupuncturist. Benefits will be paid at the regular Plan Coinsurance level. Coverage is limited to 20 visits per year. Additional acupuncture treatment may be covered by the Plan upon review by Moda Health for medical necessity.

8.6.2 Alternative Care Benefits

The Plan will pay benefits for covered expenses for chiropractic care, naturopathic care and massage therapy. Members may select any licensed chiropractor, naturopath, or massage therapist (massage therapy must be prescribed by a Professional Provider). Call Customer Service for any questions on Covered Services, limitations, exclusions and claim procedures.

The Plan will waive deductible and pay 50% of covered expenses for services provided by a licensed chiropractor, naturopath or massage therapist (massage therapy MUST be ordered by a licensed Physician, chiropractor, or naturopath to be eligible for coverage).

Benefit payments will be limited to a $300 maximum per Member per year (applicable to all Covered Services rendered by alternative care providers). Non-paid expenses, including the 50% portion that is the Member's responsibility, do not accumulate towards the medical Plan's Plan Year deductible or out-of-pocket maximum. The cost of medications/supplements dispensed by an alternative care provider directly to a Member do not accumulate towards the prescription plan's annual out-of-pocket maximum.

This specific benefit does not require the use of In Network Providers.

8.6.3 Annual GYN Examination, Mammogram and Pap Test

The Plan will cover preventive women's healthcare as follows:

If services are performed by In-Network Professional Providers, covered expenses are paid in full after a $15.00 Member Copayment. If services are performed by Out-of-Network Professional Providers, the Member will be responsible for any applicable Cost Sharing.

A complete and thorough physical examination of the breast is covered, including but not limited to a clinical breast examination, performed by a healthcare provider to check for lumps and other changes for the purpose of early detection and prevention of breast cancer as follows:

a. One annually for women Members 18 years of age and older
b. At any time at the recommendation of the Member's Professional Provider

Mammograms are covered as follows:

a. Age 35 through 39: one mammogram
b. Age 40 and older: one mammogram annually

Mammograms for the purpose of diagnosis in symptomatic or designated high risk women are covered when deemed necessary by a Professional Provider.

Mammograms done in conjunction with annual pelvic exam are subject to the $15.00 Copayment. Mammograms done more frequently (for high risk patients) or for diagnostic purposes (not in conjunction with annual pelvic exam) are subject to the deductible and appropriate Coinsurance.

Pelvic exam/pap tests are covered once annually for women of all ages, and at any time upon referral of a Professional Provider. For purpose of calculating Copayment, each pelvic exam/pap test is considered one visit.

8.6.4 Cosmetic and Reconstructive Surgery

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

Cosmetic surgery is not covered. However, reconstructive procedures that are partially cosmetic in nature may be covered if Moda Health's medical director finds the procedure to be Medically Necessary. All reconstructive procedures must be Medical Necessary and be Prior Authorized in advance of the procedure or benefits will be denied.

Treatment for complications related to a surgery performed to correct a functional disorder will be covered when Medically Necessary. Treatment for complications related to a surgery that does not correct a functional disorder is excluded.

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 8.6.17.

Coverage is also available for the following services if Prior Authorized and Medically Necessary:

a. Surgery to reduce breast size
b. Surgical repair of congenital cosmetic deformities
c. Hormone related Conditions
d. Any form of acne surgery, including cryotherapy, dermabrasion, and excision of acne scarring

8.6.5 Dental 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 under this provision:

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.)

8.6.6 Diabetes Self-Management Programs

The Plan will waive the deductible and pay 100% for covered diabetes self-management programs associated with the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and noninsulin-using diabetes, when prescribed by a Professional Provider legally Authorized to prescribe such programs. The Plan will cover one diabetes self-management program of assessment and training after diagnosis. Upon a material change of Condition, medication or treatment, the Plan will also cover up to 3 hours per year of assessment and training if:

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

8.6.7 Family Planning

Voluntary family planning services are covered when approved and arranged by the Member's Professional Provider. These services include vasectomy, tubal ligation, insertion of IUD (device included), removal of IUD (device included) and office visits related to these services. The Plan will also provide benefits for oral birth control pills and other contraceptive drugs and devices that cannot legally be dispensed without a prescription, and that by law must bear the legend "Caution-Federal law prohibits dispensing without prescription." Oral birth control pills and contraceptive drugs and devices purchased at a participating pharmacy may be covered under

the pharmacy benefit through Moda Health. Prescribed contraceptive drugs and devices received in a Professional Provider's office will be covered under the medical Plan as a supply.

8.6.8 Gender Reassignment (Transgender Surgery)

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

a. Procedure(s) must be performed by a qualified Professional Provider
b. Physician must obtain Prior Authorization the procedure (see section 6.1.2)
c. Treatment plan must conform to Harry Benjamin International Gender Dysphoria standards
d. Covered services are subject to standard plan Cost Sharing (In-Network and Out-of-Network coverage), with a benefit maximum of $75,000 per Member per lifetime
e. Covered procedures include:
    i. Single stage or multiple stage reconstruction of the genitalia
    ii. Reconstruction of breast tissue to achieve the appearance of the new gender
f. The following services are excluded from coverage by the Plan as part of Gender Identity Disorder Treatment:
    i. Treatment of acne as a complication of hormone therapy
    ii. Treatment of infertility as a complication of gender identity treatment
    iii. Reversal of gender identity treatments and surgery
    iv. Removal of beard and unwanted body hair
    v. Liposuction
    vi. Thyroid cartilage reduction
    vii. Abdominoplasty
    viii. Facial reconstruction not related to accident or Injury
    ix. Makeup evaluation
    x. Voice training
    xi. Legal expenses related to name change
    xii. Procedures and treatments that are not hormone therapy, psychotherapy or surgery for the reconstruction of genitalia
    xiii. Travel or lodging expenses

8.6.9 Hearing Aids for Enrolled Dependent Children – State of Oregon Mandated Benefit

The Plan covers one hearing aid per hearing impaired ear for enrolled dependent children up to age 26. The Plan will pay at the In-network benefit level after the deductible. Members must be examined by a Physician before obtaining a hearing aid that is prescribed, fitted and dispensed by a licensed audiologist or hearing aid specialist.

Covered services include the following every 48 months:

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

Benefits are payable up to the dollar maximum every 48 months. Covered expenses are subject to the deductible. Hearing exams are not covered in this section.

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

A "visit" means the Member is actually examined by a Professional Provider. Covered expenses include consultations with written reports as well as second opinion surgery consultations.

8.6.11 Inborn Errors of Metabolism

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

8.6.12 Maternal Diabetes Management

Covered health services, medications and supplies that are medically necessary for a woman to manage her diabetes from conception through six weeks postpartum are covered with no cost sharing.

8.6.13 Maxillofacial Prosthetic Services

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

a. Controlling or eliminating infection
b. Controlling or eliminating pain
c. Restoring facial configuration or functions such as speech, swallowing or chewing but not including cosmetic procedures to improve appearance in absence of Illness or Injury

8.6.14 Mental Health

The Plan covers Medically Necessary outpatient services by a Mental Health Provider as defined in section 5. Moda Health Behavioral Health can help Members locate In-Network Professional Providers and facilities and understand their Mental Health benefits.

8.6.15 Newborn Nursery Care

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

8.6.16 Podiatry Services

Podiatry services are covered for the diagnosis and treatment of a specific current problem. The Plan will not cover the following services unless otherwise required by the Member's Medical Condition (e.g., diabetes):

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

8.6.17 Reconstructive Surgery Following A Mastectomy (related to cancer)

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 otherwise applicable under the Plan.

8.6.18 Routine Physical Exams

The Plan will waive the deductible on covered expenses for routine physical examination, related x-rays and laboratory tests, and immunizations for Members two years of age and older. The Plan provides coverage for:

a. One Routine Physical Examination (including x-rays, labs, and immunizations) during a 12 month period for each Member age 2 and above. This benefit may be used to cover an exam to rule out a diagnosis of Illness based on family history if it fits into the one exam in a 12 month period schedule. Periodic health exams for licensing or employment purposes are not covered.

b. Baseline colonoscopy or Sigmoidoscopy: If a Member's doctor suggests that he or she have a baseline colonoscopy or sigmoidoscopy, in the absence of any prior family history of colon disease or diagnostic indicators, the cost of the routine baseline colonoscopy or sigmoidoscopy, including related facility and anesthesia fees, will be covered as part of the Routine Physical Examination benefit.

   In the absence of a diagnostic indicator, after the initial baseline colonoscopy or sigmoidoscopy, the Plan will cover one colonoscopy every 10 years and/or one sigmoidoscopy, including related facility and anesthesia fees, every 5 years as part of a Routine Physical Examination.

   Should a Member require more frequent services, those medically necessary colonoscopy or sigmoidoscopy expenses would be considered as medical expenses. All covered charges related to the procedure would be considered under the medical plan provisions, subject the Plan deductible and appropriate Coinsurance. Related facility and anesthesia fees are covered and are subject to the facility and anesthesia Coinsurance level.

c. Immunizations. Routine immunizations for both adults and children are covered when administered by their Professional Provider. Covered immunizations will be limited to those that are considered the "standard of care" by the local medical community. Immunizations for the sole purpose of travel or to prevent Illness which may be caused by a work environment are not covered.

d. **Lab work.** Covered services under the Routine Physical benefit include:

   i. Complete blood count
   ii. Urinalysis
   iii. VDRL
   iv. Tine Test
   v. Blood chemistry profile
   vi. Cholesterol test
   vii. One double contrast barium enema every 5 calendar years for members age 50 and over
   viii. One Fecal occult blood test every calendar year for members age 50 and over

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

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

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

Eligible surgery performed in a Professional Provider's office is covered, subject to the appropriate Prior Authorizations.

8.6.20 Telemedical Health Service
Covered medical services, delivered through a 2-way video communication that allows a Professional Provider to interact with a Member who is at an originating site, are covered. Benefit are subject to the applicable Cost Sharing for the covered medical services. Telemedical care for excluded services is not covered (see section 9.54).

An originating site includes the following:

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

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

8.6.21 Temporomandibular Joint Syndrome (TMJ)
All TMJ related services, including but not limited to diagnostic, surgical procedures and splints, require Prior Authorization, and will be covered only when Medically Necessary as established by a medical history of advanced pathologic process (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 Moda Health Dental Plan provided by the Group have limited coverage for nightguards under the Moda Health Dental Plan

8.6.22 Therapeutic Injections
Administrative services for therapeutic injections, such as allergy shots, are covered when given in a Professional Provider's office. When comparable results can be obtained safely with home self-care, or through oral use of a prescription drug, administrative services for therapeutic injections are not covered. (Additional information in section 8.8.1).

Vitamin and mineral injections are not covered unless Medically Necessary for treatment of a specific Medical Condition

8.6.23 Treatment for Tobacco Cessation
The Plan covers expenses incurred when a member age 15 or older participates in a tobacco cessation program. The Plan will waive the deductible and pay 100% of covered expenses. Covered expenses include counseling, office visits, medical supplies, and drugs provided or recommended by a tobacco cessation program.

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

8.6.24 Well Baby Care
The deductible will be waived for Well Baby Care. Professional Provider charges for routine Well Baby Care of the Enrolled Dependent are covered as follows:

a. The standard in-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 appropriate Cost Sharing
b. Additional office examinations of a well child during its first 24 months of life
c. Medically Necessary immunizations are covered during the child's first 24 months of life

Expenses for Well Baby Care in excess of this schedule and not medically necessary are not covered. Excess expenses do not accumulate toward the annual medical plan deductible nor the annual out-of-pocket maximum.

8.7 OTHER SERVICES

8.7.1 Biofeedback Therapy
Biofeedback therapy is covered only for the treatment of tension or migraine headaches. The Plan allows up to 10 covered visits per lifetime. Expenses for biofeedback therapy for other diagnostic Conditions or in excess of the 10 lifetime visits are not covered.

8.7.2 Home Health Care 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 Condition of the Member 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 home care visits. Home care 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 under the Plan.

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 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 8.2.8).

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 Customer Service before receiving such care.

8.7.3 Maternity Care

Pregnancy care, childbirth and related Conditions, including voluntary abortions, 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 the midwife is licensed as a certified nurse midwife or certified nurse practitioner midwife. The Plan covers facility charges for maternity care when rendered at a covered facility, including a birthing center.

Home birth expenses are not covered other than the fees billed by the Professional Provider. Additional information regarding home birth exclusions is in section 9.19.

Special Right Upon Childbirth. Benefits for any hospital length of stay in connection with childbirth for the mother or newborn child will not be restricted to less than 48 hours following a normal vaginal delivery or 96 hours following a cesarean section, unless the mother's or newborn's attending Professional Provider, after consulting with the mother, chooses to discharge the mother or her newborn earlier. Prior Authorization is not required for a length of stay up to these limits.

8.7.4 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.

8.7.5 Supplies, Appliances, and Durable Medical Equipment

Most outpatient supplies, appliances and durable medical equipment are covered. If Members receive these services from Out-of-Network Physicians or providers, the service will be reimbursed at the Out-of-Network benefit level.

a. Supplies include the following:

   i. Medical supplies used in a Professional Provider's office
   ii. Supplies for the application of a cast
   iii. Surgical supplies, including pacemakers and artificial joints
   iv. Supplies related to a colostomy or mastectomy
   v. Pumps for diabetes

b. Appliance/Brace: An appliance, including an orthopedic brace, used for performing or facilitating the performance of a particular bodily function, are covered expenses. However, the following are not covered as medical expenses: dental appliances and braces, supporting devices such as corsets or elastic stockings (except custom compression or therapeutic stockings when Medically Necessary), hearing aids except as stated in hearing aid section 8.6.9, eye glasses and contact lenses (except as covered under the vision care provision in section 8.10) see below under Intraocular Lens for the cataract surgery exception.

c. Diabetic supplies: Expenses for diabetic supplies, such as insulin, insulin syringes, disposable needles, pre-measured insulin pens or syringes, and meters are covered (see section 8.9).

d. Durable Medical Equipment: Equipment and related supplies which the Plan determines are used primarily to serve a medical purpose, are not generally useful to a person in the absence of a Medical Condition, are appropriate for use in the patient's home and are designed to withstand repeated use. Examples of durable medical equipment include a wheelchair, a hospital-type bed, and oxygen.

   The Plan covers the rental charge (not to exceed the purchase price) for durable medical equipment. Upon request, Members must authorize any supplier furnishing durable medical equipment to provide information related to the equipment order and any other records Moda Health requires to review a claim for benefit payment.

e. Intraocular Lens: The Plan covers one conventional intraocular lens or one contact lens or eyeglasses within 90 days following cataract surgery for each eye operated on.

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

g. Prosthesis: 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. Testicular prostheses are not covered.

h. 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.

   In order to obtain reimbursement for replacement or repair of appliances, including prosthetic devices, equipment or durable medical equipment, the Member must establish, to the satisfaction of Moda Health and the Plan, that the foregoing were not abused, were not used beyond their specifications and not used in a manner to void applicable warranties.

i. Exclusions for Other Services: In addition to the exclusions listed in section 9, the Plan will not cover the following appliances and equipment, regardless if they relate to a Condition which is otherwise covered by the Plan:

   A. Those used primarily for comfort, convenience, or cosmetic purposes
   B. Wigs and toupees
   C. Those used for education or environmental control, such as ramps, hand rails, bath benches, telephones, humidifiers, air filters, air conditioners, heat lamps, tanning lights, whirlpool or hot tubs
   D. Therapeutic devices, except for transcutaneous nerve stimulators
   E. Incontinence supplies

Neither Moda Health nor the Plan can be held liable for any claim or damages connected with Medical Conditions suffered by a Member arising out of the use of any durable medical equipment or due to recalled surgically implanted devices or to complications of such devices covered by manufacturer warranty.

8.7.6 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

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

   Contracting Amount means the amount the Exclusive Transplant Network Facility has agreed to accept as payment in full for facility transplant services for a specific type of transplant.

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

Transplant means a procedure or series of procedures by which:

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

Transplant Period means the time from the day of admission for transplant conditioning through the day of discharge for a transplant patient.

b. Covered Benefits for transplants are limited as follows:

i. The Plan will waive any otherwise applicable deductible and pay 80% of the contracted amount for facility fees when a transplant is performed at an Exclusive Transplant Network Facility;
ii. Transplant procedures must be performed at an Exclusive Transplant Network Facility. If an Exclusive Transplant Network Facility cannot provide the necessary type of transplant, Moda Health will prior authorize services at an alternative transplant facility;
iii. "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.

    A. If the recipient or self-donor is enrolled in the Plan, donor costs related to a covered transplant will be covered
    B. If the donor is enrolled in the Plan and the recipient is not, no benefits toward donor costs will be paid. However, expenses incurred by a covered donor which result from complications and unforeseen effects of the donation will be covered as any other sickness
    C. Expenses incurred by a donor not enrolled in the Plan which result from complications and unforeseen effects of the donation will not be covered

iv. All transplant services must be Prior Authorized. Prior Authorization requests for transplants will be reviewed to ensure the medical appropriateness and medical necessity of the proposed treatment for the Member's Medical Condition or disease.
v. Professional Provider transplant services are paid according to the benefits for Professional Providers;
vi. Immunosuppressive drugs provided during a hospital stay are paid as a medical supply. Outpatient prescription medications for transplant-related care are subject to the rules, provision, and benefit coverage available under the Prescription Drug Expense Benefit (see section 8.9).

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.

c. Prior Authorization Requirement
   Prior Authorization Procedures. The Member's Professional Provider must contact Moda Health's Medical Intake Unit prior to the transplant admission to request authorization. Prior Authorization should be obtained as soon as possible after a Member has been identified as a possible transplant candidate. A Member may obtain Prior Authorization information by contacting Customer Service.

   To be valid, Prior Authorization approval must be in writing from Moda Health.

   Prior Authorization requirements are a part of the benefit administration of the Plan. The outcome of a Prior Authorization request does not constitute a treatment recommendation or requirement. It relates solely to whether the procedure will be covered under the Plan. The actual course of medical treatment the Member chooses remains strictly a matter between the Member and his or her Physician.

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.

8.8 MEDICATIONS

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

A medication that is given by injection or infusion (intravenous administration) in the Professional Provider's office, infusion center or home infusion and supplied by the provider is covered at the same benefit level as a supply. If the pharmaceutical is available in an oral dosage form, the Plan will not cover it in the form of an injectable medication unless Moda Health agrees that it is Medically Necessary that the Member use the injectable form. In addition, infusion and in-office injectables may require Prior Authorization by Moda Health or be subject to specific benefit limitations (more information is available on the Moda Health website). Coverage under the Prescription Medication Benefit is in section 8.9.

8.8.2 Oral Anti-cancer Medication

A prescribed, orally administered anticancer medication that is given in the Professional Provider's office and supplied by the provider is covered at the same benefit level as a supply. In addition, oral anti-cancer medication may require Prior Authorization by Moda Health or be subject to specific benefit limitations (more information is available on the Moda Health website). Coverage under the Prescription Medication Benefit is in section 8.9.

8.9 PRESCRIPTION DRUG BENEFIT

8.9.1 Moda Health Preferred Pharmacy Program

Prescription Drug Benefits provide coverage for eligible outpatient prescription drug charges incurred at a retail participating Northwest Prescription Drug Consortium (NPDC) in-network pharmacy or through an exclusive mail order pharmacy. The Plan's medical deductible does not apply to prescription drugs. Moda Health maintains a Preferred Drug List (PDL) which designates the coverage tier for each medication. The tiers are: Tier 1 for Select Generic, Tier 2 for Preferred, and Tier 3 for Non-Formulary and Non-Preferred.

The Plan has a $2,000 Plan Year out-of-pocket maximum that applies to Tier 1, Tier 2, and Non-Formulary Tier 3 medications. The amount members pay toward the covered expense for these drugs 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 Plan. Once the out-of-pocket maximum is met, covered Tier 1, Tier 2, and Non-Formulary Tier 3 drugs will be reimbursed at 100%. The 50% coinsurance for Tier 3 Non-Preferred drugs that a Member must pay does not apply towards the $2,000 prescription drug out-of-pocket maximum; Members must still pay their 50% coinsurance for these drugs. The out-of-pocket maximum includes member copayment after all manufacturer discounts and/or copayment assistance programs.

8.9.2 Definitions

Brand Drugs. A brand drug 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.

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

Generic Drugs. Generic drugs have been determined by physicians and pharmacists to be therapeutically equivalent to the brand alternative and are often the most cost effective option.

Generic drugs 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.

Generic Substitution. Both generic and brand drugs are covered.

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

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

NPDC refers to Northwest Prescription Drug Consortium.

Non-Formulary Tier 3 Drugs. Non-Formulary drugs, including specialty Non-Formulary drugs, have been reviewed by Moda Health 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 drugs apply towards the out of pocket maximum.

Non-Preferred Tier 3 Drugs. These drugs generally have Tier 1 alternatives or equivalents and/or Tier 2 alternatives in the same therapy class. Because there are pharmaceutical alternatives and/or equivalents available, the coinsurance for these drugs does not apply towards the out of pocket maximum.

Over-the-Counter (OTC) Drugs. An over-the-counter drug is a drug that may be purchased without a Professional Provider's prescription according to federal guidelines. OTC designations for specific drugs vary by state. Moda Health follows the federal designation of OTC drugs to determine coverage.

Preferred Tier 2 Drugs. Drugs, including specialty preferred drugs, that have been reviewed by Moda Health and do not have significant therapeutic advantage over their preferred alternative(s). These products generally have safe and effective options available under Tier 1.

Select Generic Tier 1 Drugs. Select generic (Tier 1) drugs are generic drugs that represent the most cost effective option within their therapeutic category. This category may include certain brand drugs that have been identified as favorable from a clinical and cost effective perspective.

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

8.9.3 Covered Expenses

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

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

8.9.4 Covered Drug Supply

A covered drug supply includes the following:

a. A legend drug that is medically necessary for the treatment of a medical condition that cannot legally be dispensed without a prescription
b. Compounded drugs containing at least one covered drug as the main ingredient
c. Insulin and diabetic supplies including insulin syringes, needles and lancets, glucometers and test strips, and glucose tablets when accompanied by a valid prescription
d. Pre-packaged birth control products in 91-day supply containers will be assessed 3 copayments as defined by the Plan benefits when cost sharing is not prohibited by law
e. Select legend prenatal vitamins
f. Covered expenses for select immunizations and related administration fees are covered following regular Plan benefits (e.g. influenza, pneumonia and shingles vaccines). Covered immunizations will be limited to those that are considered the "standard of care" by the local medical community. Immunizations for the sole purpose of travel or to prevent illness which may be caused by a work environment are not covered

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

8.9.5 Retail Pharmacy benefit (limited to 30 day supply or 100 pills)

The Coinsurance for a 30 day supply from an NPDC In-network Pharmacy is:

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

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

Members have the option of obtaining prescriptions for covered drugs through an exclusive mail order pharmacy. The Coinsurance for a 90 day supply of medication from the participating Mail Order Pharmacy is:

Rx Tier	Medication Category	Member Coinsurance
Tier 1	Select Generic	20% to $35 maximum
Tier 2	Preferred	20% to $150 maximum
Tier 3	Non-Formulary	50%
Tier 3	Non-Preferred	50%

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

8.9.7 Specialty Services and Pharmacy benefit (limited to 30 day supply or 100 pills)

The pharmacist and other Professional Providers will advise a member if a prescription requires delivery by an exclusive specialty pharmacy. Specialty drugs are often used to treat complex chronic health conditions. Because specialty treatments often require special handling techniques, careful administration and a unique ordering process, the Plan provides enhanced member services for these drugs. Information about the clinical services and a list of eligible specialty drugs is available on myModa or by contacting Customer Service. **If a member does not purchase these drugs at the exclusive specialty pharmacy, the drug expense will not be covered.**

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

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

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

8.9.8 Utilization Management

8.9.8.1 Prior Authorization

Certain prescription drugs and/or quantities of prescription drugs may require prior authorization. A complete list of drugs that require prior authorization is available on myModa or by contacting Customer Service. Failure to obtain required prior authorization may result in denial of benefits or a penalty (see Section 6).

Prior authorization programs are not intended to create barriers or limit access to drugs. Drugs 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 drugs and supports cost effective treatment options for members.

8.9.9 Limitations

To ensure appropriate access to medications, the following limitations apply:

a. New FDA approved drugs are subject to review and may be subject to additional coverage requirements or limits established by the Plan
b. Select specialty drugs that have been determined to have a high discontinuation rate or short durations of use may be limited to a 15 day supply
c. Claims for drugs purchased outside of the United States and its territories will only be covered in emergency and urgent care situations
d. Early refill of medications for travel outside of the United States is limited to once every 6 months
e. Specialty drugs with dosing intervals beyond 30 days will be assessed an increased copayment consistent with the day supply

8.9.10 Exclusions

The following services, procedures and conditions are not covered by the Plan under the Prescription Drug 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. **Charges Over the Maximum Plan Allowance**
b. **Cosmetic.** Drugs prescribed or used for cosmetic purposes
c. **Devices.** Including, but not limited to therapeutic devices and appliances. Some devices could be covered under the Plan’s medical coverage
d. **Drug Administration.** A charge for administration or injection of a drug or medicine, except for select immunizations at in-network retail pharmacies. Some administration charges could be covered under the Plan’s medical coverage
e. **Drugs Covered Under Another Benefit.** Such as drugs covered under home health, medical, etc.
f. **Experimental or Investigational Drugs.** Including any drug or medicine that is used for an experimental or investigational purpose, even if it is otherwise approved by the federal government or recognized as neither experimental nor investigative for other uses or health conditions
g. **Foreign Drug Claims.** Drugs 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
h. **Hair Growth Drugs**
i. **Immunization Agents for Travel**

j. **Infertility Drugs**
k. **Institutional Drugs or Medicine.** Drugs or medications that are to be taken by or administered to a member in whole or in part while the member is a patient in a hospital, a sanitarium, a rest home, a skilled nursing facility, an extended care facility, a nursing home, or a similar institution. These drugs could be covered under the Plan's medical coverage
l. **Non-Covered Condition.** A drug prescribed for purposes other than to treat a covered medical condition
m. **Nutritional Supplements and Medical Foods.** Unless determined to be medically necessary
n. **Off-label Use.** Drugs prescribed for or used for non-FDA approved indications, unless approved by the Health Resources Commission, are not covered
o. **Over the Counter (OTC) Drugs**
p. **Repackaged Medications**
q. **Replacement Medications and/or Supplies**
r. **Sexual Dysfunction.** Drugs or devices prescribed or used to treat sexual dysfunction
s. **Treatment Not Medically Necessary.** Including:
    i. Drugs prescribed for purposes other than treating disease
    ii. Drugs that are either inappropriate or inconsistent with the symptoms or diagnosis of a member's condition
    iii. Drugs that are not representative of the standard treatment by the medical community in the service area in which they are received
    iv. Drugs that are primarily rendered for the convenience of a member or provider
    v. Drugs that are not a cost effective option when considering common alternatives that can be safely provided to a member
t. **Untimely Dispensing.** Drugs or medicines that are dispensed more than one year after the order of a Professional Provider
u. **Vitamins and Minerals.** The Plan does not cover over-the-counter (OTC) vitamins and minerals
v. **Weight Loss Drugs**

8.9.11 Pharmacy Coordination of Benefits (COB)

Claims subject to the COB provision of the Plan may be submitted electronically by pharmacies or through the direct member reimbursement paper claim process. The preferred method is for the pharmacy to electronically transmit the primary plan's remaining balance to Moda Health for processing. If approved, the secondary claim will be automatically processed according to plan benefits. Members who are unable to have their secondary claims processed electronically may submit a claim reimbursement request directly to Moda Health (see section 10.1).

8.9.12 COB Processing Guidelines

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

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

Approved by Primary:

a. **Primary plan approves a claim, but does not pay anything toward the claim.** Reasons for this may include, but are not limited to; the member has not satisfied a deductible (if

applicable) or the cost of the medication is less than the primary plan's copayment or coinsurance. In this scenario, Moda Health will pay as if it is primary.

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

Additional information on COB is in Section 11.

8.9.13 Appeal Process For Prescription Drug 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 drug out-of-pocket maximum. The formal written request should be submitted to:

ATTN: Rx Prior Auth – Multnomah County Tiering Request
Moda Health Plan, Inc.
601 SW Second Avenue
Portland, OR 97204
Fax 800-207-8235

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.

8.10 VISION CARE BENEFIT

8.10.1 Vision Care Benefits

The Plan provides each Member with coverage for the following vision care services.

a. Vision Examinations – Eye exams, including refraction or complete visual examination, are covered when performed by an ophthalmologist or optometrist. The Plan pays 100% of the Maximum Plan Allowance for Out-of-Network providers or contracted rate for In-Network providers. If a Member uses an Out-of-Network provider, he or she may have to pay a portion of the exam cost.

b. Glasses – For Members age 19 and over, hardware (frames and lenses) are payable at 100% of billed charges up to the maximum allowed benefit (listed below) for prescribed lenses and frames to correct vision. Members are responsible for charges in excess of the listed Maximum Allowed Benefit.

	Maximum Allowed Benefit
Single Vision (each lens)	$ 52.50
Bifocal Vision (each lens)	$ 65.00
Trifocal Vision (each lens)	$ 75.00
Lenticular (each lens)	$100.00
Frames	$ 90.00

For Members under age 19, hardware (frames and lenses) are payable at 100% of contracted rates for In-Network providers and 100% of the Maximum Plan Allowance for Out-of-Network providers. If a Member uses an Out-of-Network provider, he or she may have to pay a portion of the glasses cost.

Benefits for one pair of lenses and one frame are payable once every two years.

c. Contact Lenses - Contact lenses may be selected in lieu of lenses and frames.

For Members age 19 and over, contact lenses are covered at the single vision lens rate plus frame rate above, unless required for cataract surgery or as the only method to correct vision to 20/70 or better. Contact lenses required after cataract surgery or as the only means to correct vision to 20/70 or better are covered at 100% of the allowed charge.

For Members under age 19, contact lenses are payable at 100% of contracted rates for In-Network providers and 100% of the Maximum Plan Allowance for Out-of-Network providers. If a Member uses an Out-of-Network provider, he or she may have to pay a portion of the contact lenses cost.

8.10.2 Limitations

These vision care benefits are provided as shown above once every year for the vision exam, and once every two years for two lenses, and one pair of frames (or a Member may elect to purchase a pair of contact lenses in lieu of the glasses.)

8.10.3 How To Use the Vision Care Plan

When Members need vision care or an examination, they should make an appointment with a licensed ophthalmologist or optometrist of their choice. To file a claim, write the Group and identification numbers on the top of an itemized statement obtained from the Professional Provider and send this statement to Moda Health.

8.10.4 Services Not Covered

a. Treatment of eyes or special procedures such as orthoptics or vision training.
b. Sunglasses or other special purpose vision aids. (lenses with tints other than #1 or #2 are considered sunglasses.)
c. Replacement or duplication of lost, stolen, broken or duplicate lenses and frames at any time Member is not ordinarily eligible for new lenses or frames.
d. Eye examinations required by an employer.
e. Services or supplies already covered under the medical benefits of the Plan.

This vision care coverage is part of a Member's health plan. Therefore, he or she may not transfer it to any non-group plan if the Member leaves his or her employment.

SECTION 9. GENERAL EXCLUSIONS

In addition to the limitations and exclusions described elsewhere in the Plan, the following services, procedures and Conditions are **not covered,** even if otherwise Medically Necessary, if they relate to a Condition that is otherwise covered by the Plan, or if recommended, referred, or provided by a treating Professional Provider.

9.1 Benefits Not Stated

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

9.2 Charges Over the Maximum Plan Allowance

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

9.3 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.

9.4 Cosmetic Procedures

Any procedure requested for the purpose of improving or changing appearance without restoring impaired body function, including breast augmentation, lipectomy, liposuction, and hair removal (including electrolysis and laser). Exceptions are provided for reconstructive surgery following a mastectomy (see section 8.7.18) and complications of reconstructive surgeries if medically necessary and not specifically excluded.

9.5 Counseling or 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 treatment of "normal" transitional response to stress.

9.6 Court-Ordered Services

Those related to unlawful behavior by the member, including a sex offender treatment program. This exclusion does not apply to services provided pursuant to civil commitment proceedings for Mental Illness.

9.7 Custodial Care

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

9.8 Dental Examinations and Treatment or Orthodontia

Except as specifically provided for in section 8.6.5 or if medically necessary to restore function due to craniofacial anomaly. *(Members who have elected to Enroll in the Moda Health Dental Plan should refer to that plan for dental and orthodontic coverage.)*

9.9 Enrichment Programs

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

9.10 Experimental or Investigational Procedures
Including expenses incidental to or incurred as a result of such procedures.

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

9.12 Family Planning
Services and supplies for family planning (except for birth control pills, sterilization and services covered under section 8.6.7); surgery to reverse voluntary sterilization procedures (vasectomy or tubal ligation); diagnosis and treatment of infertility; and artificial insemination procedures, including, but not limited to, in-vitro fertilization (IVF), Gamete Intrafallopian Transfer (GIFT), Zygote Intrafallopian Transplant (ZIFT), and Tubal Embryo Transplant (TET) are not covered.

9.13 Financial Counseling Services
Are not covered.

9.14 Food Services
"Meals on Wheels" and similar programs are not covered.

9.15 Guest Meals in a Hospital or Skilled Nursing Facility
Are not covered.

9.16 Hearing Aids
Including:

a. Implantable hearing aids and surgical procedure to Implant them
b. Hearing exams
c. Hearing aids for enrolled children beyond age limits stated in section 8.6.9
d. Replacement of a hearing aid, for any reason, within the required time period
e. Batteries or other supplementary equipment other than those obtained upon purchase of the hearing aid
f. A hearing aid exceeding the specifications prescribed for correction of hearing loss
g. 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

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

9.18 Homemaker or Housekeeping Services
Are not covered.

9.19 Homeopathy
Homeopathy treatment, including remedies, are not covered.

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

9.21 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.

9.22 Learning Disabilities
Expenses for the diagnosis and treatment of learning disabilities are not covered.

9.23 Legal Counseling
Is not covered.

9.24 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 provision of Mental Health or Chemical Dependency services as provided under the Plan.

9.25 Mental Retardation
Treatment related to mental retardation for Members age 18 or older and custodial services or supplies provided by an institution for the mentally retarded.

9.26 Midwives
Except a licensed and certified nurse midwife or nurse practitioner midwife.

9.27 Missed Appointments
Charges by a Professional Provider or any other Provider for scheduled appointments that were missed by a Member.

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

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

9.30 Obesity or Weight Reduction
Even if morbid obesity is present. Services and supplies including but not limited to:

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, or any form of relaxation training as well as subliminal suggestion used to modify eating behaviors
c. Any drug or formula related to or resulting from the treatment of weight loss or obesity even if prescribed by a Professional Provider

The Plan will cover services and supplies that are necessary for the treatment of established Medical Conditions that may be caused by or made worse by obesity, but services and supplies that do so by treating the obesity directly are not covered.

9.31 Orthopedic Shoes
Except as provided for in section 8.7.5.

9.32 Orthognathic Surgery
Services and supplies associated with orthognathic surgery.

9.33 Pastoral and Spiritual Counseling
Are not covered.

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 8.2.8 and 8.5.3.

9.39 Reports and Records
Separate charges for the completion of reports or claim forms 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. Paring or cutting of benign hyperkeratotic lesion (e.g., corn or callus)
b. Trimming of dystrophic and non-dystrophic nails
c. Debridement of nail(s) by any method(s)

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

9.42 Services Otherwise Available
Including:

a. those 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. those 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. those for which no charge is made, or for which no charge is normally made in the absence of health coverage
d. those 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. those 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 rendered 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

9.43 Services Provided by a Relative
Except as specifically provided for in section 8.7.2, services provided by a Member 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.

9.44 Services Provided By Volunteer Workers
Are not covered.

9.45 Service, War or Insurrection
The Plan does not cover treatment of any Condition caused by or arising out of services in the armed forces of any country or the active participation in any war or insurrection, or the voluntary participation in a riot or rebellion.

9.46 Sexual Disorders
The Plan does not cover services or supplies for sexual dysfunction except for services delivered by Mental Health Providers for the treatment of sexual dysfunction diagnoses listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders.

9.47 Support Education
Including the following:

a. Level 0.5 education-only programs
b. Education-only, court-mandated Anger Management classes
c. Voluntary mutual support groups, such as Alcoholics Anonymous are not covered
d. Family education or support groups

9.48 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."

9.49 Surgery to Alter Refractive Character of the Eye
Except as otherwise provided under the Plan, any procedure which alters the refractive character of the eye, the purpose of which is to cure or reduce myopia, hyperopia, or astigmatism are not covered. Includes reversals or revisions of any procedures that alter the refractive character of the eye and any complications of these procedures are not covered.

9.50 Taxes
Are not covered.

9.51 Telemedical Health Services

Including telephone visits or consultations and telephone psychotherapy, except as specifically provided for in section 8.6.20.

9.52 Telephones and Televisions in a Hospital or Skilled Nursing Facility

Are not covered.

9.53 Therapies

Services or supplies related to mental retardation for Members age 18 or older, or related to learning disabilities, hippotherapy, 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. This includes benefits payable under any automobile medical, personal injury protection (PIP), automobile no fault, underinsured or uninsured, homeowner, commercial premises coverage, or similar contract or insurance, when such contract or insurance is issued to, or makes benefits available to, a Member, whether or not such benefits are requested (see section 10.4.2).

9.55 Transportation

Except Medically Necessary ambulance transport.

9.56 Treatment After Coverage Terminates

The only exception is if a Member is hospitalized at the time of coverage termination (see section 4.2), or for covered hearing aids ordered before coverage terminates 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 wigs, 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.

9.58 Treatment Not Medically Necessary

Including services or supplies that:

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

> **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.**

9.59 Treatment Prior to Enrollment

Including services and supplies for an admission to a hospital, skilled nursing facility or special facility that began before the member's coverage under the Plan began. Reimbursement for such admission will be the responsibility of the plan under which the member was covered immediately preceding and extending up to the effective date of the Plan. If no such plan was in effect, 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.

9.60 Vision Care

Any charges for orthoptics, vitamin therapy, low vision therapy, eye exercises, or fundus photography, except as otherwise provided under the Plan.

9.61 Vitamins and Minerals Dispensed by a Professional Provider

Unless FDA approved and Medically Necessary for treatment of a Medical Condition and only if they bear the legend "Caution – Federal law prohibits dispensing without a prescription" and a dosage form of equal or greater strength of the medication is not available without a prescription under federal law. This applies whether the vitamin or mineral is oral, injectable, or transdermal.

9.62 Work-Related Conditions

Treatment of a Medical Condition arising out of or in the course of employment or self-employment for wages or profit, whether or not the expense is paid under any workers' compensation provision. 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 AND PAYMENT OF CLAIMS

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

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

10.1.1 Hospital and Professional Provider Claims

A Member who is hospitalized or visits a Professional Provider must present his or her Moda Health identification card to the admitting or treating office. In most cases, the hospital or Professional Provider will bill Moda Health directly for the cost of the services. 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 under the Plan.

Sometimes a hospital or Professional Provider will require a Member, at the time of discharge or treatment, to pay charges that might not be covered by the Plan. If this happens, the Member must pay these amounts. The Plan will reimburse the Member if any of the charges paid by the Member 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. Member's name (who received treatment)
b. Subscriber's name and Group's 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 (AMA) CPT and/or Centers for Medicare and Medicaid (CMS) HCPCS codes

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

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

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 Subscriber name, identification number, and Group number.

10.1.4 Tobacco Cessation Program Claims

Members should follow the claim submission procedures in section 10.1.5 for prescribed or OTC drugs treating tobacco cessation. A specific claim form is available on myModa or by contacting Moda Health Customer Service.

Moda Health will be billed directly by the exclusive tobacco cessation program for the cost of counseling, consultation and supplies. Other providers may require a member to pay the charges and submit the claim to Moda Health. If this happens, the member must pay these amounts and submit the claim form specific to the tobacco cessation program. Moda Health will reimburse the member for covered expenses.

10.1.5 Prescription Medication Claims

To ensure timely processing of a reimbursement request, Members should complete the prescription medication claim form to request benefit reimbursement for prescribed drugs. Forms are available on myModa.

Submit the claim to: Moda Health Pharmacy Network
P.O. Box 40168
Portland, OR 97240-0168

10.1.6 Explanation of Benefits (EOB)

Soon after receiving a claim, Moda Health will report its action on the 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 accumulated toward satisfying the deductible, if any. 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.

10.1.7 Payment of Benefits

If Moda Health receives 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.

10.1.8 Claim Inquiries

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

10.1.9 Time Frames for Processing Claims

If a claim is denied, Moda Health will send an EOB to the Subscriber explaining the denial within 30 days after receiving the claim. If additional time is needed to process the claim for reasons beyond Moda Health's control, a notice of delay will be send to the Subscriber explaining those reasons within 30 days after Moda Health receives the claim. Moda Health will then complete its processing and send an EOB to the Subscriber no more than 45 days after receiving the claim. If additional information is needed to complete processing 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.

If the delay notice requests coordination of benefits information, Moda Health will issue an EOB within 44 days after receiving the claim.

10.1.10 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 within 2 business days. The response time will be expedited if the Member has an urgent Medical Condition.

10.2 APPEALS AND EXTERNAL REVIEW

If a Member is dissatisfied with the handling of a claim, there are specific procedures to request a review, as explained in this section.

10.2.1 Definitions

For purposes of section 10.2, the following definitions apply:

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

Appeal is a written request by a Member or his or her representative for Moda Health to review an Adverse Benefit Determination.

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

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

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

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

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

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

10.2.2 Time Limit For Submitting Appeals

A Member has **180 days** from the date of an Adverse Benefit Determination to submit an initial written Appeal. If an Appeal is not submitted within the timeframes outlined in this section, the rights to the Appeals process will be lost.

10.2.3 The Review Process

The Plan has a 2-level internal review process consisting of a first level appeal and a second level appeal. If a Member is not satisfied with the outcome of the second level appeal, and the dispute meets the specifications outlined in section 10.2.6, the Member may request external review by an independent review organization. The first and second levels of appeal must be exhausted to proceed to external review, unless the Plan agrees otherwise.

The Member will be allowed to receive continued coverage of an approved and ongoing course of treatment pending conclusion of the internal appeal process.

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

10.2.4 First Level Appeals

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

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

lapse between the first level appeal determination and receipt of the second level appeal by Moda Health. If the Member fails to provide sufficient information for Moda Health to make a decision at each appeal level, Moda Health will notify the member within 24 hours of receipt of the appeal of the specific information necessary to make a decision. The Member must provide the specified information as soon as possible.

Investigation of a non-urgent care pre-service appeal will be completed within 15 days. Investigation of a non-urgent care post-service appeal or a complaint will be completed within 30 days.

When an investigation has been completed, Moda Health will notify the Member in writing of the decision, the basis for the decision, and if applicable, information on the right to a second level appeal.

10.2.5 Second Level Appeals

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

Investigations and responses to a second level appeal will be by persons who were not involved in the initial determinations, 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 rationale is used by Moda Health in connection with the claim, it will be provided to the Member, in advance and free of charge, before any final internal adverse benefit determination. Members may respond to this information before Moda Health's determination is sent. Moda Health will notify the Member in writing of the decision, the basis for the decision, and if applicable, information on the right to request an external review.

10.2.6 External Review

If the dispute meets the criteria below, a Member may request that it be reviewed by an Independent Review Organization, appointed by the Oregon Insurance Division.

a. The dispute must relate to an Adverse Benefit Determination based on a utilization review decision; or whether a course or plan of treatment that a Member is undergoing is an active course of treatment for purposes of continuity of care (see section 10.3); or cases in which Moda Health fails to meet the internal timeline for review or to the federal requirements for providing related information and notices;
b. The request for external review must be in writing no more than the 180 days after receipt of the Final Internal Adverse Benefit Determination;
c. The Member must have exhausted the Appeal process described in sections 10.2.3 and 10.2.4. However, the Plan may waive this requirement and have a dispute referred directly to external review with the Member's consent, For an urgent care claim or when the dispute concerns a condition for which a Member received emergency services and is still hospitalized, a request for external review may be expedited or simultaneous with a request for internal appeal review; and

The Member must sign a waiver granting the Independent Review Organization access to his or her medical records. The Member, the Group, and Moda Health shall provide complete and accurate information to the Independent Review Organization in a timely manner.

The decision of the independent review organization is binding except to the extent other remedies are available to the Member under state or federal law.

A Final Internal Adverse Benefit Determination based on specific exclusions or limitations on the amount, duration or scope of coverage that does not involve medical judgment or a decision on whether a person is a Member under the Plan does not qualify for external review. A complaint decision does not qualify for external review.

10.2.7 Complaints

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

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

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

10.2.8 Additional Member Rights

Members may contract 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

Continuity of care allows a Member who is receiving care from an individual Professional Provider to continue care with the individual Professional Provider for a limited period of time after the Medical Services Contract terminates.

The Plan will provide continuity of care if a Medical Services Contract or other contract for a Professional Provider's services is terminated, the provider no longer participates in the Provider Network, and the Plan does not cover services when services are provided to Members by the individual provider or covers services at a benefit level below the benefit level specified in the Plan for Out-of-Network Professional Providers.

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

a. The Member must request continuity of care from the Plan
b. The Member is undergoing an active course of treatment that is Medically Necessary and, by agreement of the individual provider and the Member, it is desirable to maintain continuity of care
c. The contractual relationship between the individual provider and Moda Health, with respect to the Plan covering the Member has ended

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

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

a. Because the Professional Provider:

   i. has retired
   ii. has died
   iii. no longer holds an active license
   iv. has relocated out of the Service Area
   v. has gone on sabbatical
   vi. is prevented from continuing to care for patients because of other circumstances; or

b. The contractual relationship has terminated in accordance with provisions of the Medical Services Contract relating to quality of care and all contractual appeal rights of the individual Professional Provider have been exhausted.

The Plan will not provide continuity of care if the Member leaves the Plan or if the Group discontinues the Plan in which the Member is enrolled.

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

a. The day following the date on which the active course of treatment entitling the Member to continuity of care is completed; or
b. The 120th day after the date of notification by Moda Health to the Member of the termination of the contractual relationship with the individual Professional Provider.

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

a. The 45th day after the birth; or
b. As long as the Member continues under an active course of treatment, but not later than the 120th day after the date of notification by Moda Health to the Member of the termination of the contractual relationship with the individual Professional Provider.

10.3.3 Notice Requirement
Moda Health will give written notice of the termination of the contractual relationship with an individual Professional Provider and of the right to obtain continuity of care to those Members that Moda Health knows or reasonably should know are under the care of the individual Professional Provider. The notice shall be given to the Members no later than the 10th day after the date on which the termination of the contractual relationship takes effect or no later than the 10th day after Moda Health first learns the identity of an affected Member after the date of termination of the contractual relationship.

If the individual Professional Provider belongs to a provider group, the provider group may deliver the notice if the notice clearly provides the information that the Plan is required to provide to the affected Member.

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

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 the section titled "Coordination of Benefits."

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 benefits or healthcare costs were paid by the Plan. For example, a Member who is injured may be able to recover the benefits or healthcare costs from an individual or entity responsible for the Injury or from an insurer, including different forms of liability insurance, or uninsured motorist coverage or under-insured motorist coverage. As another example, a Member may become sick or be injured in the course of employment, in which case the employer or a workers' compensation insurer may be responsible for healthcare expenses connected with the Medical Condition. If the Plan makes an advance payment of benefits, as described below, it is entitled to be reimbursed for any benefits it paid that are associated with any Medical Condition that are or may be recoverable from a Third Party or other source. Amounts received by the Plan through these recoveries help reduce the cost of premiums and providing benefits.

Payment of benefits where a Third Party may be legally liable is excluded under the terms of the Plan. Because recovery from a Third Party may be difficult and take a long time, as a service to the Member, the Plan may pay such expenses based on the understanding and agreement that the Member is required to honor the Plan's subrogation rights as discussed below and, if requested, to reimburse the Plan in full from any recovery the Member may receive, no matter how the recovery is characterized.

Upon claiming or accepting benefits, or the provision of benefits, under the terms of the Plan, the Member agrees that the Plan has the remedies and rights described in this Section. The Plan may elect to 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 Plan's right of reimbursement or subrogation as discussed in this Section. Moda Health has the sole discretion to interpret and construe these reimbursement 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 Plan, or submitted to Moda Health for payment to or on behalf of a Member. Bills, statements or invoices submitted to Moda Health by a provider of services, supplies or facilities to or on behalf of a Member are considered requests for payment of "benefits" by the Member.

b. **Third Party Claim** means any claim, lawsuit, settlement, award, verdict, judgment, arbitration decision or other action against a Third Party (or any right to assert the foregoing) by or on behalf of a Member, regardless of the characterization of the claims or damages of the Member, and regardless of how the claims or damages or recovery funds are characterized. (For example, a Member who has received payment of medical expenses from the Plan, may file a Third Party claim against the party responsible for the Member's injuries, but only seek the recovery of non-economic damages. In that case, the Plan is still entitled to recover benefits as described herein.)

c. **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.

d. **Recovery Funds** means any amount recovered from a Third Party.

10.4.2.2 Subrogation

Upon payment by the Plan, the Plan shall be subrogated to all of the Member's rights of recovery. The Member shall do whatever is necessary to secure such rights and do nothing to prejudice them.

Moda Health may pursue the Third Party in the Plan's name, or in the name of the Member. The Plan is entitled to all subrogation rights and remedies under the common and statutory law, as well as under the Plan.

10.4.2.3 Right of Recovery

In addition to its subrogation rights, the Plan may, at its sole discretion and option, ask that a Member, and his or her attorney, if any, protect its reimbursement rights. The following rules apply to this right of recovery:

a. The Member holds any rights of recovery against the Third Party in trust for the Plan, but only for the amount of benefits the Plan paid for that Medical Condition.

b. The Plan is entitled to receive the amount of benefits it has paid for that Medical Condition out of any settlement or judgment which results from exercising the right of recovery against the Third Party. This is so regardless of whether the Third Party admits liability or asserts that the Member is also at fault. In addition, the Plan is entitled to receive the amount of benefits it has paid whether the health care expenses are itemized or expressly excluded in the Third Party recovery.

c. If Moda Health asks the Member, and his or her attorney, to protect the Plan's reimbursement 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.

d. Moda Health may ask the Member to sign an agreement to abide by the terms of this Right of Recovery section. The Plan will not be required to pay benefits for the Medical Condition until the agreement is properly signed and returned.

e. 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 Plan's recovery rights will not be reduced due to the Member's own negligence.

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

10.4.2.4 Motor Vehicle Accidents

Any expense for a Medical Condition that results from a motor vehicle accident, and which is payable under a motor vehicle insurance policy is not a covered benefit under the Plan and will not be paid by the Plan.

If a claim for healthcare expenses arising out of a motor vehicle accident is filed with the Plan, and if motor vehicle insurance has not yet paid, then the Plan may advance benefits, subject to section 10.4.2.2.

In addition, in Third Party claims involving the use or operation of a motor vehicle, the Plan, at its sole discretion and option, is entitled to seek reimbursement under the Personal Injury Protection statutes of the state of Oregon, including ORS 742.534, ORS 742.536, or ORS 742.538 or under other applicable state law.

10.4.2.5 Additional Third Party Liability Section Provisions

In connection with the Plan's rights as discussed in sections 10.4.1 through 10.4.2.4, Members shall do one or more of the following and agree that Moda Health may do one or more of the following, at its discretion:

a. If the Member seeks payment by the Plan of any benefits for which there may be a Third Party Claim, the Member shall notify Moda Health of the potential Third Party Claim. The Member has this responsibility even if the first request for payment of benefits is a bill or invoice submitted to the Plan by the Member's provider.

b. Upon request from Moda Health, the Member shall provide all information available to the Member, or any representative, or attorney representing the Member, relating to the potential Third Party Claim. 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 Plan from the Third Party.

c. A Member seeking advance payment of benefits by the Plan in accordance with section 10.4.2, must fill out, sign and return to Moda Health a Third Party Reimbursement Questionnaire and Agreement. If the Member is a minor or legally incapable of contracting, then the Member's parent or guardian must sign, and if the Member has retained an attorney, then the attorney must also sign the agreement.

d. The Member shall cooperate with Moda Health to protect the Plan's recovery rights under this Section, and in addition, but not by way of limitation, shall:

   i. Sign and deliver any documents Moda Health reasonably requires to protect the Plan's rights
   ii. Provide any information to Moda Health relevant to the application of the provisions of this Section, including medical information (doctors' reports, chart notes, diagnostic test results, etc.), settlement correspondence, copies of pleadings or demands, and settlement agreements, releases or judgments
   iii. Take such actions as Moda Health may reasonably request to assist Moda Health in enforcing the Plan's Third Party recovery rights

e. By accepting the payment of benefits by the Plan, the Member agrees that Moda Health has the right to intervene in any lawsuit or arbitration filed by or on behalf of a Member seeking damages from a Third Party.

f. The Member agrees that Moda Health may notify any Third Party, or Third Party's representatives or insurers of the Plan's recovery rights set forth herein.

g. 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 this Section.

h. This Section applies to any Member for whom advance payment of benefits is made by the Plan whether or not the event giving rise to the Member's injuries occurred before the Member became covered by the Plan.

i. If the Member continues to receive medical treatment for a Medical Condition after obtaining a settlement or recovery from a Third Party, the Plan will provide benefits for the continuing treatment of that Medical Condition only to the extent that the Member can establish that any sums that may have been recovered from the Third Party have been exhausted.

j. If the Member or the Member's representatives fail to do any of the foregoing acts at Moda Health's request, then the Plan has the right to not advance payment of benefits or to suspend payment of any benefits for or on behalf of the Member related to any sickness, Illness, Injury or Medical Condition arising out of the event giving rise to, or the allegations in, the Third Party Claim. In exercising this right, Moda Health may notify medical providers seeking Authorization or pre-Authorization of payment of benefits that all payments have been suspended, and may not be paid.

k. 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.

l. If any term, provision, agreement or condition of this Section 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.

10.5 Medicare – Parts A and B

To the extent permitted by law, the Plan will not pay toward any part of a covered expense to the extent the expense is actually paid or would have been paid(*) under Medicare Part A or B had the Member properly enrolled and applied for Medicare benefits at initial Medicare eligibility date. 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. To the extent allowable under those Medicare rules and regulations, the Plan will not pay benefits toward any part of a covered expense to the extent the covered expense is covered by Medicare Parts A or B.

(*) 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 Parts A and/or B, this Plan will estimate the Medicare benefit on any claims submitted for consideration and calculate this Plan's benefit based on that estimate.

SECTION 11. COORDINATION OF BENEFITS (COB)

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

Plan does not include:

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

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

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

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

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

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 rather than cash payments, the reasonable cash value of the service will also be considered an allowable expense and a benefit paid. An expense that is not covered by any plan covering the Member is not an allowable expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a Member is not an allowable expense.

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

a. The difference between the cost of a semi-private hospital room and a private hospital room, unless one of the plans provides coverage for private hospital room expenses;
b. The amount of the reduction by the primary plan because a Member has failed to comply with the plan provisions concerning second surgical opinions or prior Authorization of admissions or services, 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 or services 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 or services 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 or service for a specific negotiated fee or payment amount that is different than the primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the allowable expense used by the secondary plan to determine its benefits.
f. If a plan is advised by a Member that all plans covering the Member are high-deductible health plans and the Member intends to contribute to a health savings account established in accordance with Section 223 of the Internal Revenue Code of 1986, the primary high-deductible health plan's deductible is not an allowable expense, except for any healthcare expense incurred that may not be subject to the deductible as described in Section 223(c)(2)(C).

This Plan is the part of this Group Health Plan 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, Subscriber, or retiree, then that plan will determine its benefits before a plan that covers the person 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 person as a Dependent and primary to the plan covering the person 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:
        A. The plan covering the custodial parent;
        B. The plan covering the spouse or Domestic Partner of the custodial parent;
        C. The plan covering the non-custodial parent; and then
        D. The plan covering the 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. **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 a Member as a laid off or retired employee (or as that employee's Dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of the benefits, this rule is ignored.
g. **COBRA or State Continuation Coverage.** If a Member whose coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the Member as an employee, member of an

organization, Subscriber, or retiree or as a Dependent of the same, is the primary plan and the COBRA or other continuation coverage is the secondary plan. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of the benefits, this rule is ignored.

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

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 Moda Health's Right To Collect And Release Needed Information

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

11.6 Correction Of Payments

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

11.7 Right Of Recovery

If the Plan pays more for a covered expense than is required by the Plan, the excess payment may be recovered from:

a. The Subscriber
b. Any person to whom the payment was made
c. Any insurance company, service plan or any other organization that should have made payment

11.8 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 Parts A and/or B are still subject to Coordination of Benefits. Moda Health will estimate the benefits payable by Medicare and process claims from the secondary position based on those estimates.

SECTION 12. MISCELLANEOUS PROVISIONS

12.1 REQUEST FOR INFORMATION

When necessary to process claims, Moda Health may require that a Member to submit information concerning benefits to which the Member is entitled. Moda Health may also require a Member to authorize any Professional Provider to give Moda Health information about a Condition for which a Member claims benefits.

12.2 CONFIDENTIALITY OF MEMBER INFORMATION

Keeping a Member's protected health information confidential is of extreme importance to the Plan. Protected health information includes enrollment, claims, and medical and dental information. Such information is used for claims payment, referrals and Authorization of services, and business operations such as case management and quality management programs. Moda Health does everything possible to protect PHI. The Notice of Privacy Practices provides more information about how the Group uses such information. Moda Health as the third party administrator is 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 Plan. These benefits are not assignable or transferable to anyone else. Any attempted assignment or transfer will not be binding on Moda Health nor the Plan, except that Moda Health shall pay amounts due under the Plan directly to a provider upon a Member's written request.

12.4 RECOVERY OF BENEFITS PAID BY MISTAKE

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

12.5 CONTRACT PROVISIONS

The agreement between the Group and Moda Health and this handbook plus any endorsements or amendments are the entire contract between the parties. No promises, terms, conditions or obligations exist other than those contained in the contract. This handbook and the agreement between the Group plus any endorsements or amendments shall supersede all other communications, representations or agreements, either verbal or written between the parties.

12.6 REPLACING ANOTHER PLAN

If the Plan replaces an earlier Moda Health or other Group Health Plan, benefits and deductibles will be applied as follows:

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

12.7 RESPONSIBILITY FOR QUALITY OF MEDICAL CARE

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

12.8 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.

12.9 NO WAIVER

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

12.10 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.

12.11 GOVERNING LAW

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

12.12 WHERE ANY LEGAL ACTION MUST BE FILED

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

12.13 TIME LIMITS FOR FILING A LAWSUIT

Any legal action arising out of, or related to, the Plan and filed against the Plan by a Member or any third party, must be filed in court within 3 years of the time the claim arose. All internal levels of appeal under the Plan must be exhausted before filing a claim in court.

12.14 EVALUATION OF NEW TECHNOLOGY

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

SECTION 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 any one of the following labor contracts, and work at least 20 hours a week on a regular basis in a permanent position for the Group:

a. Multnomah County Deputy Sheriff's Association
b. International Union of Operating Engineers, Local 701
c. Multnomah County Corrections Deputy Association
d. Multnomah County Federation of Oregon Parole and Probation Officers
e. Multnomah County Prosecuting Attorney Association.

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

A person is not eligible to Enroll under the Plan if he or she works in a position covered by the AFSCME Local 88 General Contract, the AFSCME Local 88 Juvenile Custody Service Specialists Contract, the AFSCME Local 88-4 Physicians Contract, the IBEW Local 48 contract, the IUPAT Local 1094 Contract or the Oregon Nurses Association Contract for the Group.

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 Non-Represented position or from a position covered by the AFSCME Local 88 General Contract, the AFSCME Local 88 Juvenile Custody Service Specialists Contract, the AFSCME Local 88-4 Physicians Contract, the IBEW Local 48 contract, the IUPAT Local 1094 Contract or the Oregon Nurses Association Contract.

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 Handicapped Child

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 the handicapped child 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 incapacity 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. For the purposes of this handbook, mental incapacity means intellectual competence usually characterized by an IQ of less than 70 and physical incapacity means the inability to pursue an occupation or education because of a physical impairment.

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. **<u>This initial review must be completed in advance of the child losing eligibility for coverage</u>**. The documentation should be submitted 90 days in advance of the loss of coverage event. If request is approved, the child's medical documentation/condition will be subject to periodic review by a Moda Health medical consultant, except in cases where the disability is certified to be permanent.

13.3 QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

The Plan will cover persons deemed to be alternative recipients under a Qualified Medical Child Support Order (QMCSO). A QMCSO is a court judgment, decree, or order, or a state administrative order that has the force and effect of law, that is typically issued as part of a divorce or as part of a state child support order proceeding, and that requires health plan coverage for an alternative recipient. An alternative recipient is a child of an Eligible Employee who is recognized under a medical child support order as having a right to enrollment under a Group Health Plan with respect to such Eligible Employee.

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.

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.

13.4 NEW DEPENDENTS

Generally a Subscriber has 90 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 request is filed within that enrollment period. Should the Subscriber fail to submit an enrollment request 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 contact the Group to obtain a Benefit Enrollment Change form and an Affidavit of Marriage or Domestic Partnership form. These forms must be completed, signed, and submitted to the Group during the 90 days immediately following the marriage date. If submitted during the 90 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

<u>State of Oregon Domestic Partner Registry</u>: 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 contact the Group to obtain a Benefit Enrollment Change form and an Affidavit of Marriage or Domestic Partnership form. These forms must be completed, signed and submitted during the 90 days immediately following the Domestic Partner registry and submitted (along with a copy of the Domestic Partner Registry certificate) to the Group during that period. If

submitted during the 90 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 contact the Group to obtain a Benefit Enrollment Change form and an Affidavit of Marriage or Domestic Partnership form. These forms must be completed, signed and submitted during the 90 days immediately following the Domestic Partner registry and submitted (along with a copy of the Domestic Partner County Registry certificate) to the Group during that period. If submitted during the 90 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 contact the Group to obtain a Benefit Enrollment Change form and an Affidavit of Marriage or Domestic Partnership form. These forms must be completed and signed during the 90 days immediately following the end of the six month residency requirement and submitted to the Group during that period. If submitted during the 90 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 should contact the Group to obtain a Benefit Enrollment Change form to continue coverage beyond the 31-day period. The completed and signed change form must be submitted to the Group within 90 days of the child's birth. Coverage for the child will terminate after 31 days unless the Subscriber has submitted a completed Benefit Enrollment Change form to the Group. If the change form is submitted after coverage is terminated but within 90 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 90 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 90 days of birth by submitting a completed Benefit Change Form to the Group, 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 request enrollment for a newborn grandchild within 90 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 should obtain a Benefit Enrollment Change form from the Group to continue coverage beyond the first 31 days. The completed and signed change form with the placement or adoption documentation must be submitted to the Group within 90 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 Patient Protection and Affordable Care Act (PPACA) 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 a 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 completed and signed Benefit Enrollment application for the Eligible Employee/Subscriber and any Dependents to be enrolled must be filed with the Group 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 form is submitted within the 31 day enrollment period, **coverage begins on the first of the month following the Group's receipt of the Benefit Enrollment application. If the first of the month is a business day and forms are received on that day, coverage will begin immediately.**
b. If Benefit Enrollment form is not submitted within the 31-day enrollment period, the employee will be enrolled by default in the least costly plan option provided by the Group (i.e., the Major Medical Plan) 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 submitting a completed and signed Benefit Change form and appropriate Affidavit to the Group within 90 days of the eligibility event.

a. If Benefit Change form is filed during the 90-day enrollment period, **coverage for new Dependent(s) begins on the first of the month following the Group's receipt of the Benefit Change form and appropriate Affidavit. If the first of the month is a business day and forms are received on that day, coverage will begin immediately.**
b. If Benefit Change form is not filed during the 90-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 a completed and signed Benefit Change form to the Group requesting enrollment of the child within 90 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 90 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 the Group's receipt of a completed and signed Benefit Enrollment Change form, 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 90 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 90 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 90 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 because of other health coverage, an Eligible Employee or any Dependent(s) may Enroll in the Plan outside of the open enrollment period, but only if the following criteria are met:

a. The Eligible Employee or Dependent was covered under a Group Health Plan or had health insurance coverage at the time coverage was previously offered;
b. The Eligible Employee stated in writing at such time that coverage under a Group Health Plan or health insurance coverage was the reason enrollment was declined;
c. The Eligible Employee requests such enrollment not later than 90 days after the previous coverage ended; and
d. One of the following events has occurred:

    i. The Eligible Employee's or Dependent's 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. The Eligible Employee's or Dependent's prior coverage was terminated 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. termination of employment
        F. reduction in the number of hours of employment
        G. reaching the lifetime maximum on all benefits
        H. the plan ceasing to offer coverage to a group of similarly situated persons
        I. moving out of an HMO Service Area that results in termination of coverage 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 the employee's or Dependent's other coverage were terminated. (If employer contributions cease, the Eligible Employee or Dependent does not have to terminate coverage under the prior plan in order to be eligible for special enrollment.)
    iv. The Eligible Employee's or dependent's prior coverage was under Medicaid or a children's health insurance program (CHIP) and such coverage was terminated due to loss of eligibility.

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 90 days of the determination of eligibility, they may Enroll in the Plan outside of the open enrollment period.

The special enrollment rights, as described in sections 14.5.1 and 14.5.2, apply:

a. To an Eligible Employee who loses other coverage or becomes eligible for a premium assistance subsidy
b. To a Subscriber's Dependent who loses other coverage or becomes eligible for a premium assistance subsidy

c. To both the Eligible Employee and the Dependent if neither is enrolled in the Plan, and either loses other coverage or becomes eligible for a premium assistance subsidy

To Enroll, an Eligible Employee will need to submit a complete and signed Benefits Change Form, Affidavit of Marriage or Domestic Partnership, if applicable, along with a Certificate of Creditable Coverage (or other documentation showing loss of coverage) from the previous plan.

14.5.3 Acquisition of New Dependents

When an Eligible Employee or Subscriber acquires a new Dependent through birth, marriage, adoption or placement of adoption, the following persons are eligible to Enroll in the Plan:

a. an Eligible Employee who is not enrolled
b. an Eligible Employee who is not enrolled, and the spouse/Domestic Partner of such employee
c. an Eligible Employee who is not enrolled, and the newly-acquired Dependent of such employee
d. the spouse/Domestic Partner of the Eligible Employee or Subscriber
e. a newly-acquired Dependent of the Eligible Employee or Subscriber

The employee, spouse/Domestic Partner and new Dependent children have special enrollment rights, but other existing Dependent children who are not enrolled do not, and they may be enrolled at the next open enrollment.

No waiting period may apply, if enrollment is submitted within the 90-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 Benefit Change form is submitted. Once marriage has occurred, coverage begins the first day of the month following the date the Group receives the completed and signed Benefit Change form and Affidavit of Marriage/Domestic Partnership. If the first of the month is a business day and forms are received 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 file a signed Benefit Change form to add the infant during that period. If Benefit Change form is submitted within 90 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 the timely submission of a completed and signed Benefit Change form and adoption paperwork.

14.6 TERMINATION OF COVERAGE

The circumstances which a Member's coverage will end are described in the following sections. When the Subscriber's coverage ends, coverage for all Enrolled Dependents also ends unless the Dependent/s are eligible for continuation under Section 14.6.14 or Section 15.

14.6.1 Plan Termination

If the Plan is terminated for any reason, coverage ends for the 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 90 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 a Benefits Change form choosing the Opt-Out option, and proof of new coverage, including the start date, within 90 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 forms are received 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 by the Plan
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. 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 file 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 file 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 handicapped child 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 ORS 743.600 to 743.602 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 and 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 legally separated or divorced spouse or Domestic Partner 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 fails to notify the surviving spouse or Domestic Partner, within the required 44 days, 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. Failure to exercise this election within 60 days of the notification shall terminate the right to continued benefits under this section.

d. Premiums for 55+ Oregon Continuation Coverage

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

a. Failure to pay premiums when due, including any grace period allowed by the Plan
b. The date the Plan terminates, unless a different Group Health Plan is made available to Group Members
c. The date the surviving, legally separated or divorced spouse, or the surviving, legally separated or former Domestic Partner, becomes covered under any other Group Health Plan
d. The date the member becomes covered under another Group Health Plan
e. The date the member becomes eligible for Medicare

14.6.15 Uniformed Services Employment and 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).

14.6.16 Certificates of Creditable Coverage
Certificates of Creditable Coverage as required by HIPAA will be automatically issued by Moda Health when coverage ends, when COBRA coverage ends, and when a Member requests a certificate while enrolled in the Plan or within two years of losing coverage. Members should contact Moda Health to request a copy of the Certificate of Creditable Coverage.

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 Plan 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 Plan is not obligated to offer greater rights than the COBRA statute requires
b. The Plan 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 or legal separation from the Subscriber
d. Termination or dissolution of a qualifying Domestic Partnership
e. The Subscriber becomes entitled to Medicare

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

Children
A child of a Subscriber has the right to continuation coverage if coverage is lost for **any** of the following 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, legal separation 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 And Election Requirements

Qualifying Event Notice. A Member’s coverage will terminate on the date according to section 14.6 when a divorce or legal separation 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 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 to:

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

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, no COBRA continuation of coverage offer will be made.

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

15.5 COBRA PREMIUMS

Members eligible for continuation coverage do not have to show that they are insurable. However, they are responsible for all premiums for continuation coverage. 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). This payment must include the amount necessary to cover all months that have elapsed between the date regular coverage ended and the COBRA premium payment date.

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. However, 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, in good funds, 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

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

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.
In the case of a coverage loss due to a Subscriber's death, divorce, legal separation, 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 under the Plan 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

If COBRA is elected, an extension of the maximum period of coverage may be available if a Member is disabled or a second qualifying event occurs. The 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 fails to 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 at some time before the 61st day after the Subscriber's termination of employment or reduction of hours and must last at least until the end of the period of COBRA coverage that would be available without the disability extension (generally 18 months). Each Member who has elected COBRA coverage will be entitled to the disability extension if one of them qualifies.

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

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

A Member must provide the COBRA Administrator a copy of the Social Security Administration's determination within the 18-month period following the Subscriber's termination of employment or reduction of hours, and not later than 60 days after the Social Security Administration's determination was made. If the notice is not provided within this timeframe, then there will be no disability extension of COBRA coverage. The 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. Such second qualifying events may include the death of a Subscriber, divorce or legal separation, 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 due to a second qualifying event is available only if the COBRA Administrator is notified in writing of the second qualifying event within 60 days after the date of the second qualifying event. If this notice is not provided to the 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 14.6.13).

15.8 Newborn or Adopted Child

If, during the COBRA continuation coverage period, 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 90 days of the birth or placement to obtain continuation coverage. Enrollment of an additional Dependent may increase the cost of coverage. If the Subscriber or family member fails to notify the COBRA Administrator in a timely manner, the child will not be eligible for continuation coverage.

15.9 Special Enrollment and 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 newborns, new spouse or Domestic Partner, and adopted children (or children placed for adoption) as Enrolled Dependents in accordance with the Plan's eligibility and enrollment rules, 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 automatically terminate before the end of 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 section 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 terminated 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. PATIENT PROTECTION ACT

The intent of the Patient Protection Act is to assure, among other things, that patients, Physicians and providers are informed about their health insurance plans. This section outlines some of the Plans important terms and conditions.

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

Members have the right to:

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

Members have the responsibility to:

a. Read this handbook to make sure they understand the Plan. Members are advised to call Moda Health Customer Service or Multnomah County Benefits Office with any questions.
b. Treat all Providers and their staff with courtesy and respect.
c. Provide all the information needed for their Provider to provide good healthcare.
d. Participate in making decisions about their medical care and forming a treatment plan.
e. Follow instructions for care they have agreed to with their Provider.
f. Use urgent and emergency services appropriately.
g. Present their medical identification card when seeking medical care and inform Providers they are covered by Moda Health.
h. Notify Providers of any other insurance policies that may provide coverage.
i. Reimburse the Plan from any third party payments they may receive.
j. Keep appointments and be on time. If this is not possible, Members must call ahead to let the Provider know they will be late or cannot keep their appointment.
k. Seek regular health checkups and preventive services.

l. Provide adequate information to the Plan 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 be filed?

A Member can file an appeal by contacting Moda Health Customer Service or by writing a letter to Moda Health (P.O. Box 40384, Portland, Oregon 97240). Complete information is in section 10.2.

A member may also 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

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 Customer Service or visit myModa for a list of 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 rendered 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 Member's 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 formed some advisory committees, including the Group Advisory Committee for employers and the Quality Council for healthcare professionals, to allow participation in the development of corporate policies and to provide feedback. Committee membership is limited. Members may obtain more information by contacting Moda Health at:

   Moda Health
   601 S.W. Second Avenue
   Portland, Oregon 97204
   www.modahealth.com

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

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

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

P.O. Box 40384
Portland, OR 97240

modahealth.com