



2026

Oregon Group Medical and Prescription Plan

Salem Health Hospitals and Clinics
Choice Plan - MHP
Preferred Provider Organization (PPO) plan
Group# 10001832
January 1, 2026

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

ModaORLGASObk 1-1-2026



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SECTION 1. WELCOME TO MODA HEALTH

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

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

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

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

SECTION 2. MEMBER RESOURCES

2.1 CONTACT INFORMATION

Moda Health Website (log in to your **Member Dashboard**)

www.modahealth.com

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

- Find an in-network provider with Find Care
- Get medication cost estimates and benefit tiers using our Prescription Price Check tool and formulary
- See if a service or supply you need must be prior authorized first (Referral and Authorization link under Resources)

Medical Customer Service Department

855-425-4543

En español 888-786-7461

Behavioral Health Customer Service Department

800-799-9391

Modern Health

866-535-6463

Modern Health (<https://my.joinmodernhealth.com>)

Disease Management and Health Coaching

800-913-4957

Hearing Services preferred vendor

TruHearing

866-202-2178

Pharmacy Customer Service Department

833-212-5030

Appeals Department

601 SW 2nd Ave., Portland, OR 97204

Fax 503-412-4003

OregonExternalReview@modahealth.com

Telecommunications Relay Service for the hearing impaired

711

Moda Health

P.O. Box 40384

Portland, Oregon 97240

2.2 MEMBER ID CARD

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

You may also access tools and resources on Moda Health's personalized member website, the Member Dashboard, at www.modahealth.com. The Member Dashboard is available 24 hours a day, 7 days a week allowing you to access plan information whenever it's convenient.

2.3 NETWORKS

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

Medical network

Medical Networks for subscribers living in Oregon, Southwest Washington, Alaska and Idaho

- a. Tier I: Salem Health Hospitals & Clinics and facilities and West Valley Hospital
- b. Tier II: Connexus
- c. Tier III: Connexus – for a complete list of tier III provider groups and facilities, please visit www.modahealth.com/salemhealth. For information on how to search for specific providers see Section 5.2.

Medical Networks if a subscriber resides outside the Connexus service area:

- a. Tier I: Salem Health Hospitals & Clinics and facilities and West Valley Hospital
- b. Tier II: Aetna® PPO for subscribers living in other states, with service area in most states other than Alaska, Idaho, Oregon and southwest Washington

Eligibility for out-of-area plans is determined by the group, reach out to the group for additional information.

Pharmacy network

Pharmacy network is ArrayRx Core Network

Travel network

Aetna® PPO Network through Aetna Signature Administrators®

2.4 CARE COORDINATION

2.4.1 Care Coordination

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

2.4.2 Disease Management & Health Coaching

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

2.4.3 Behavioral Health

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

2.5 OTHER RESOURCES

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

SECTION 3. SCHEDULE OF BENEFITS

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

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

You will find details of the actual benefits in the sections after this summary. You will need to know the conditions, limitations and exclusions of the Plan that are explained there. Prior authorization may be required for some services (see Section 6). Important terms are explained in Section 12.

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

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

	<u>Tier I Benefits</u>	<u>Tier II Benefits</u>	<u>Tier III Benefits</u>	<u>Tier IV Benefits</u>
Annual deductible per member	None	\$750	\$1,500	\$1,500
Maximum annual family aggregate deductible	None	\$1,500	\$3,000	\$3,000
Maximum out-of-pocket per member	\$2,500	\$3,500	\$5,900	\$5,900
Maximum annual aggregate out-of-pocket per family	\$5,000	\$7,000	\$11,800	\$11,800

Benefits	Amount You Pay				Section in Handbook & Details
	In-Network			Out-of-Network	
	Tier I	Tier II	Tier III	Tier IV	
Urgent & Emergency Care					
Ambulance Transportation	N/A	10% Tier I out-of-pocket maximums apply			Section 7.2.1
Emergency Room Facility (includes ancillary services)	\$250 per visit	\$250 per visit Tier I out-of-pocket maximums apply			Section 7.2.2 No copay if admitted to hospital from emergency room
Emergency Room Facility – Physicians fees	0%	0% Tier I out-of-pocket maximums apply			

Benefits	Amount You Pay				Section in Handbook & Details
	In-Network			Out-of-Network	
	Tier I	Tier II	Tier III	Tier IV	
Urgent Care Office Visit					Section 7.2.6
Mental health or substance use disorder	0%	0%	0%	0%	
Other services	\$20 per visit	\$40 per visit	\$50 per visit	40% after deductible	
Preventive Services					
Services as required under the Affordable Care Act, including:	0%			40% after deductible	Section 7.3
Colonoscopy	0%			40% after deductible	Section 7.3.1 One per 10 years, age 45+
Contraception	0%			40% after deductible	Section 7.3.2
Immunizations	0%			40% after deductible	Section 7.3.3
Mammogram	0%			40% after deductible	Section 7.3.8 One per year, age 40+
Pediatric Screenings	0%			40% after deductible	Section 7.3.4 Age/frequency limits apply
Preventive Health Exams	0%			40% after deductible	Section 7.3.5 6 visits first year of life 7 exams from age 1 – 4 One per year, age 5+
Preventive X-ray & Lab	0%			40% after deductible	Section 7.3.5
Tobacco Cessation Treatment					Section 7.3.7
Consultation	0%	0%		40% after deductible	
Supplies		10% after deductible			
Women's Exam & Pap Test	0%			40% after deductible	Section 7.3.8 One per year

Benefits	Amount You Pay				Section in Handbook & Details
	In-Network			Out-of-Network	
	Tier I	Tier II	Tier III	Tier IV	
Other preventive services, including:					
Screening X-ray & Lab	0%	10% after deductible	10% after deductible	40% after deductible	Section 7.4.9
Prostate Rectal Exam	\$0 per visit			40% after deductible	Section 7.3.6 Once every year, age 50+
Prostate Specific Antigen (PSA) Test	0%			40% after deductible	
General Treatment Services					
Acupuncture	0%	\$20 per visit	\$20 per visit	40%	Section 7.4.1 20 visits per year
Allergy Injections	0%	\$10 per visit after deductible	\$10 per visit after deductible	40% after deductible	Section 7.4.35
Anticancer Medication	0%	10% after deductible	10% after deductible	40% after deductible	Section 7.4.2
Applied Behavior Analysis	0%			40% after deductible	Section 7.4.3
Behavioral Health Services					
Detoxification (Detox)	0%	10% after deductible	10% after deductible	40% after deductible	Section 7.4.4
Office Visits	0%			0%	
Intensive Outpatient	0%				
Other Outpatient Services	0%	10% after deductible	10% after deductible	40% after deductible	
Coordinated Specialty Programs	0%				
Inpatient	0%	10% after deductible	10% after deductible		
Partial Hospitalization					
Residential Treatment Program					
Chemo/Radiation Therapy	0%	10% after deductible	10% after deductible	40% after deductible	Section 7.4.36
Dental Injury	0%	10% after deductible	10% after deductible	40% after deductible	Section 7.4.7
Diabetes Services	0%	10% after deductible	20% after deductible	40% after deductible	Section 7.4.8 Supplies covered under Pharmacy benefits

Benefits	Amount You Pay				Section in Handbook & Details
	In-Network			Out-of-Network	
	Tier I	Tier II	Tier III	Tier IV	
Diagnostic Procedures, including x-ray and lab					Section 7.4.9
Outpatient	0%	10% after deductible	20% after deductible	40% after deductible	
Inpatient	0%	10% after deductible	20% after deductible		
Advanced Imaging - Inpatient	0%	10% after deductible	10% after deductible		
Disease Management for Pain	0%			40% after deductible	Section 7.4.10
Durable Medical Equipment (DME) Supplies & Appliances	0%	10% after deductible	10% after deductible	40% after deductible	Section 7.4.11
Hearing Aids & Related Services					Section 7.4.13
Exam	\$0	\$20 per visit	\$20 per visit	40% after deductible	Age/frequency limits apply
Other Services	0%	10%	10%	40% after deductible	\$1,500 maximum every 3 years for members age 26 and over
Home Healthcare	0%	10% after deductible	10% after deductible	40% after deductible	Section 7.4.14 100 visits per year
Hospice Care					Section 7.4.15
Home Care	0%	10% after deductible	10% after deductible	40% after deductible	
Inpatient Care	0%	10% after deductible	10% after deductible	40% after deductible	
Respite Care	0%	10% after deductible	10% after deductible	40% after deductible	
Hospital Inpatient Care	0%	10% after deductible	20% after deductible	40% after deductible	Section 7.4.16
Hospital Physician Visits	0%	10% after deductible	20% after deductible	40% after deductible	Section 7.4.17
Infusion Therapy					Section 7.4.20
Home Infusion	N/A	10% after deductible	10% after deductible	40% after deductible	Some medications may be limited to certain providers or settings Certain medications covered under specialty pharmacy benefit
Outpatient Infusion	0%	10% after deductible	20% after deductible		

Benefits	Amount You Pay				Section in Handbook & Details
	In-Network			Out-of-Network	
	Tier I	Tier II	Tier III	Tier IV	
Kidney Dialysis Outpatient	N/A	10% after deductible	10% after deductible	40% after deductible	Section 7.4.21
Kidney Dialysis Inpatient	0%	10% after deductible	10% after deductible		
Massage Therapy	0%	\$20 per visit	\$20 per visit	40%	Section 7.4.22 \$1,000 per year
Nutritional Therapy					Section 7.4.26
Preventive (as required under Affordable Care Act)	0%			40% after deductible	
Treatment (medical and behavioral health)	0%	10% after deductible	20% after deductible		
Office and Home Visits	0%	10% after deductible	20% after deductible	40% after deductible	Section 7.4.27
Specialist Visits	0%	10% after deductible	20% after deductible	40% after deductible	
Office Services (other than outpatient surgery and x-ray and lab tests)	0%	10% after deductible	20% after deductible	40% after deductible	
Rehabilitation & Habilitation (Physical, occupational and speech therapy)					Section 7.4.30 Maximums per year for outpatient: 60 visits for physical therapy, 60 visits for occupational therapy, 60 visits for speech and hearing therapy. Habilitation only covered outpatient, for mental health conditions
Outpatient	0%	10% after deductible	20% after deductible	40% after deductible	
Inpatient	0%	10% after deductible	20% after deductible		
Skilled Nursing Facility Care	N/A	10% after deductible	10% after deductible	40% after deductible	Section 7.4.31 120 days per year
Spinal Manipulation	0%	\$20 per visit	\$20 per visit	40%	Section 7.4.32 20 visits per year

Benefits	Amount You Pay				Section in Handbook & Details
	In-Network			Out-of-Network	
	Tier I	Tier II	Tier III	Tier IV	
Surgery and Invasive Diagnostic Procedures					Section 7.4.33
Outpatient	0%	10% after deductible	20% after deductible	40% after deductible	
Inpatient	0%	10% after deductible	20% after deductible	40% after deductible	
Bariatric Surgery Facility charge	0%	10% after deductible	10% after deductible	Not covered	See section 7.4.33 for limitations regarding facilities \$90,000 lifetime maximum
Bariatric Surgery Physician charge	0%	10% after deductible	10% after deductible		
Telemedicine	Paid same as any other condition	Paid same as any other condition	Paid same as any other condition	Not covered	Section 7.4.38
Temporomandibular Joint Syndrome (TMJ)					Section 7.4.34 \$3,000 lifetime maximum on all related services
Office visits	0%	\$20 per visit after deductible	\$20 per visit after deductible	40% after deductible	
All other services	0%	10% after deductible	20% after deductible	40% after deductible	
Therapeutic Injections	0%	10% after deductible	20% after deductible	40% after deductible	Section 7.4.35
Therapeutic Radiology	0%	10% after deductible	10% after deductible	40% after deductible	Section 7.4.36
Transplants					Section 7.4.37
Center of Excellence facilities	N/A	10% after deductible	10% after deductible	N/A	
Other facilities	0%	10% after deductible	10% after deductible	Not covered	
Donor Costs					Section 7.4.37
Center of Excellence facilities	N/A	10% after deductible	10% after deductible	N/A	
Other facilities	0%	10% after deductible	10% after deductible	Not covered	
Travel Expenses	0%	10% after deductible	10% after deductible	N/A	\$10,000 lifetime maximum

Benefits	Amount You Pay				Section in Handbook & Details
	In-Network			Out-of-Network	
	Tier I	Tier II	Tier III	Tier IV	
Additional Cost Tier (for certain outpatient and hospital services)					
Advanced Imaging - Outpatient	0%	10% after deductible	\$100 copay, then 20% after deductible	\$100 copay, then 40% after deductible	Section 4.1 Copayment applies per procedure or study
Sleep Studies	0%	\$100 copay, then 20% after deductible	\$100 copay, then 20% after deductible	\$100 copay, then 40% after deductible	
Upper Endoscopy	0%	\$100 copay, then 20% after deductible	\$100 copay, then 20% after deductible	\$100 copay, then 40% after deductible	
Spinal Injections	0%	\$100 copay, then 20% after deductible	\$100 copay, then 20% after deductible	\$100 copay, then 40% after deductible	
Viscosupplementation	0%	\$100 copay, then 20% after deductible	\$100 copay, then 20% after deductible	\$100 copay, then 40% after deductible	
Tonsillectomy	0%	\$100 copay, then 20% after deductible	\$100 copay, then 20% after deductible	\$100 copay, then 40% after deductible	
Lumbar Discography	0%	\$100 copay, then 20% after deductible	\$100 copay, then 20% after deductible	\$100 copay, then 40% after deductible	
Arthroscopy (knee and shoulder)	0%	\$500 copay, then 20% after deductible	\$500 copay, then 20% after deductible	\$500 copay, then 40% after deductible	
Spine Surgery	0%	\$500 copay, then 20% after deductible	\$500 copay, then 20% after deductible	\$500 copay, then 40% after deductible	
Uncomplicated Hernia Repair	0%	\$500 copay, then 20% after deductible	\$500 copay, then 20% after deductible	\$500 copay, then 40% after deductible	
Knee or Hip Replacement	0%	\$500 copay, then 20% after deductible	\$500 copay, then 20% after deductible	\$500 copay, then 40% after deductible	

Benefits	Amount You Pay				Section in Handbook & Details
	In-Network			Out-of-Network	
	Tier I	Tier II	Tier III	Tier IV	
Maternity Services					
Breastfeeding					Section 7.5.2
Support and Counseling	0%			40% after deductible	
Supplies				0%	
Maternity	0%	10% after deductible	20% after deductible	40% after deductible	Section 7.5
Supportive Services (pre- and post-natal, labor and delivery)	N/A			20% after deductible Tier III deductible and out-of-pocket apply	\$3,760 per year
Abortion	0%			40% after deductible	Section 7.5.5
Newborn Home Visiting Program	0%			40% after deductible	Section 7.5.5 Visit limits apply

Benefits	Amount You Pay		Section in Handbook & Details
	In-Network	Out-of-Network	
Pharmacy			
Prescription Medication	If you use an out-of-network pharmacy, you must pay any amounts charged above the MPA		Section 7.6
Salem Health Retail Pharmacy & Salem Health River Road Pharmacy			Up to 90-day supply per prescription \$35 max cost share for insulin \$105 max cost share for insulin
Preventive	No cost sharing	N/A*	
Value	\$2 for 30-day supply; \$6 for 90-day supply	N/A*	
Select	25%, \$5 minimum and \$25 maximum	N/A*	
Preferred	30%, \$5 minimum and \$75 maximum	N/A*	
Nonpreferred	50%, \$5 minimum and no maximum	N/A*	

Benefits	Amount You Pay		Section in Handbook & Details
	In-Network	Out-of-Network	
ArrayRx Core Network Pharmacy			Up to 30-day supply per prescription \$35 max cost share for insulin
Preventive	No cost sharing	N/A*	
Value	\$2	N/A*	
Select	35%, \$15 minimum and \$25 maximum	N/A*	
Preferred	40%, \$15 minimum and no maximum	N/A*	
Nonpreferred	50%, \$15 minimum and no maximum	N/A*	
*Out-of-Network Pharmacy benefits are detailed in the Other Retail Pharmacies section to follow			
Other Retail Pharmacies			Up to 30-day supply per prescription \$35 max cost share for insulin
Preventive	N/A	50%	
Value	N/A	50%	
Select	N/A	50%	
Preferred	N/A	50%	
Nonpreferred	N/A	50%	
Mail Order Pharmacy			Up to 90-day supply per prescription \$105 max cost share for insulin
Preventive	No cost sharing	Must use a Moda-designated mail order pharmacy	
Value	\$6		
Select	25%, \$5 minimum and \$25 maximum		
Preferred	30%, \$5 minimum and \$75 maximum		
Nonpreferred	50%, \$5 minimum and no maximum		
Specialty Pharmacy			Up to 30-day supply per prescription for most medications \$35 max cost share for insulin
Select	25%, \$5 minimum and \$25 maximum	Must use a Moda-designated specialty pharmacy	
Preferred	30%, \$150 maximum		
Nonpreferred Specialty	50%		
Anticancer Medication	Same as any other medications	Same as any other medications	Section 7.4.2

SECTION 4. PAYMENT & COST SHARING

4.1 ADDITIONAL COST TIER

Some surgical procedures have less invasive options. When you get these procedures, you will have to pay a copayment in addition to the standard cost sharing. Additional cost tier procedures are:

\$100 cost tier:

- a. Advanced Imaging outpatient procedures
- b. Lumbar discography
- c. Sleep studies
- d. Spinal injections
- e. Tonsillectomy if you are under age 18 and have chronic tonsillitis or sleep apnea
- f. Upper endoscopy
- g. Viscosupplementation

\$500 cost tier:

- a. Arthroscopy (knee and shoulder)
- b. Hip replacement
- c. Knee replacement
- d. Knee/hip replacement
- e. Spine surgery
- f. Uncomplicated hernia repair

More information is on your Member Dashboard, or ask Customer Service for more information about the additional cost tier. Also see sections 7.4.33 for imaging and surgery benefits generally.

4.2 DEDUCTIBLES

Every year, you will have to pay some expenses before the Plan starts paying. This is called meeting or satisfying your deductible. The deductible is lower when you use in-network providers. You must pay all covered expenses until you have spent the deductible amount, unless the Plan specifically says there is no deductible. Then the Plan begins sharing costs with you. The deductible amounts, and the amount you pay after the deductible is met, are shown in Section 3. Deductibles are combined across the tiers and are not added up separately. If more than one member of your family is covered, you only have to pay your per member deductible until the total family deductible is reached.

Disallowed charges, copayments, and manufacturer discounts and/or copay assistance programs do not count toward your annual deductible.

If you are admitted in one calendar year and discharged in the following calendar year, you will be responsible for the deductible in the new calendar year for any services that are billed with a date of service in that year.

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

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

4.3 MAXIMUM OUT-OF-POCKET

The Plan helps protect you from very high medical costs. The out-of-pocket maximum is an upper limit on how much you have to pay for covered charges each year. Once you have paid the maximum amount, the Plan will pay 100% of covered services for the rest of the year. If more than one member of your family is covered, the per member maximum applies only until the total family out-of-pocket maximum is reached, even if no single family member has reached the per member maximum. Out-of-pocket amounts are combined across the tiers and are not added up separately.

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

If you are admitted in one calendar year and discharged in the following calendar year, you will be responsible for the annual out of pocket maximum in the new calendar year for any services that are billed with a date of service in that year.

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

You will always have to pay disallowed charges, even after your out-of-pocket maximum is met. Disallowed charges may include amounts over the MPA, out of pocket expenses for hearing aids (after plan limit has been met) and extra expenses you pay when you use a brand medication when a generic is available.

4.4 PAYMENT

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

Covered expenses are paid based on the maximum plan allowance (MPA). The MPA is defined in Section 12. You may have to pay some of the charges (cost sharing). What you have to pay depends on the Plan provisions. Even though some services are paid when provided by a Tier IV professional provider, such services are subject to maximum plan allowance and balance billing.

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

4.5 EXTRA-CONTRACTUAL SERVICES

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

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

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

SECTION 5. NETWORK INFORMATION

Tier I benefits apply to services delivered by Salem Hospitals & Clinics and facilities and West Valley Hospital. Tier II and Tier III benefits apply to services delivered by Connexus providers. Tier II offers access to provider and clinics that generally offer services that are not available at Salem Health Hospitals and Clinics. Tier III offers access to specific hospital systems, ambulatory surgery centers and provider clinics that generally provide the same services as Salem Health Hospitals and Clinics. Visit modahealth.com/salemhealth for a list of Tier III providers. For members residing in states other than Oregon or Southwest Washington, Alaska and Idaho, Tier II benefits apply to services delivered by Aetna® PPO providers. Tier IV benefits apply to services delivered by out-of-network facilities and providers. For information on how to search for specific providers see Section 5.2. When you use an in-network provider, you will receive quality healthcare and will have a higher level of benefits. Use Find Care on your Member Dashboard to choose an in-network provider. You may contact Customer Service if you need help. Your member ID card will list your network.

When you are at an in-network facility, your care may be provided by physicians, anesthesiologists, radiologists or other professionals who are not in-network. When you receive services from these out-of-network providers, you may have to pay any amounts charged above the MPA (see section 5.1.2). This is called balance billing. Remember to ask providers to send any lab work or x-rays to an in-network facility.

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

If you are on approved personal leave for the purpose of aiding disaster relief efforts, and there is no in-network provider in the area for an eligible service or supply, the Plan will pay benefits at the Tier II level.

5.1 GENERAL NETWORK INFORMATION

5.1.1 Network and Service Area

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

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

Networks

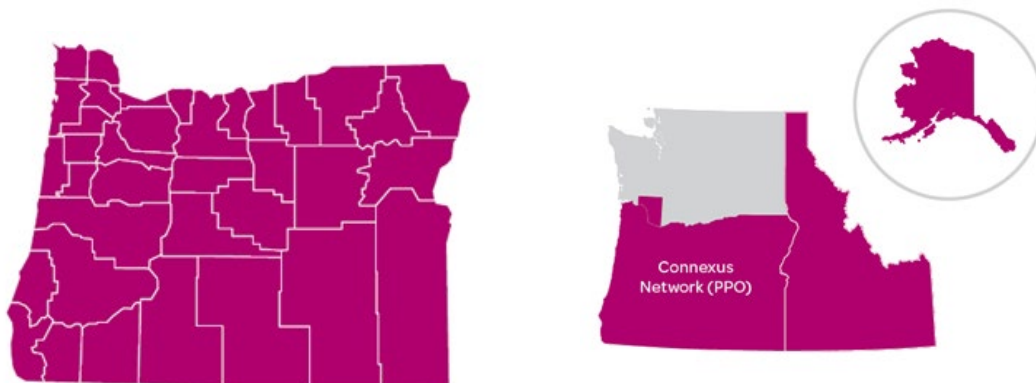
Medical Networks for subscribers living in Oregon, Southwest Washington, Alaska and Idaho

- a. Tier I: Salem Health Hospitals & Clinics and facilities and West Valley Hospital
- b. Tier II: Connexus
- c. Tier III: Connexus – for a complete list of tier III provider groups and facilities, please visit www.modahealth.com/salemhealth. For information on how to search for specific providers see Section 5.3.

Medical Networks if a subscriber resides outside the Connexus service area:

- a. Tier I: Salem Health Hospitals & Clinics and facilities and West Valley Hospital
- b. Tier II: Aetna® PPO for subscribers living in other states, with service area in most states other than Alaska, Idaho, Oregon and southwest Washington

Eligibility for out-of-area plans is determined by the group, reach out to the group for additional information.



Pharmacy network is ArrayRx Core Network

Out-of-Area Network for Dependents

This provision applies to members who are enrolled in the Connexus Network.

Enrolled dependents living in the United States but outside the primary service area may be assigned to the out-of-area network and will receive Tier II benefits.

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

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

Out-of-Area Network

Aetna® PPO

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

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

Travel Network

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

You may only use a travel network provider if:

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

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

Travel Network

Aetna® PPO

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

5.1.2 Out-of-Network Care

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

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

Special Circumstances

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

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

In-network benefits are not automatic (except for emergency services). You or your provider must ask us to prior authorize in-network benefits (see section 6.1.3). We will review your request, and if the criteria are met, we will pay at the in-network benefit level. You will have to pay any charges that are over the maximum plan allowance.

5.1.3 Care after Normal Office Hours

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

5.1.4 Primary Care Provider (PCP)

The Plan is designed to support your healthcare needs through partnership between you and an in-network primary care provider (PCP) who can coordinate your care. You must choose an in-network PCP group and tell us who it is when you enroll. If you do not, we will assign one to you. A PCP group is the primary care group (such as a clinic) where PCPs work, and is where you access primary (non-specialty) care.

You can change your PCP group at any time through your Member Dashboard or by calling Customer Service. Use Find Care on your Member Dashboard to see a list of in-network PCPs, or ask Customer Service for help. Each member of your family may choose a different PCP group.

A PCP may be a family or general practitioner, a pediatrician or a women's healthcare provider. A women's healthcare provider is an in-network:

- a. Obstetrician or gynecologist
- b. Physician associate, advanced registered nurse practitioner or naturopathic physician specializing in women's health
- c. Certified nurse midwife practicing within their lawful scope of practice

To select a women's healthcare provider as your PCP, they must meet certain standards and must have requested and received designation from us as a PCP.

5.2 USING FIND CARE

Find Care is our online directory of in-network providers. To search for in-network providers, go to www.modahealth.com and click on Find Care. Search as a member by entering your ID number found on the front of your Member ID card. Search for a specific provider by name, specialty or type of service, or look in a nearby area using ZIP code or city. If your provider is in-network, their network tier will be indicated as follows:

- a. Salem Health Tier I network shows providers within Salem Health Hospitals & Clinics and facilities and West Valley Hospital.
- b. Salem Health Tier II network shows Connexus providers available under Tier II benefits. Tier II providers are identified as Connexus network providers in the search results.
- c. Salem Health Tier III network shows Connexus providers available under Tier III benefits. Tier III providers are identified as Salem Health Connexus Tier III network providers in the search results.

5.2.1 Primary Care

To use this plan, you must choose a PCP group, where you will access primary care. To find a PCP group:

- a. Choose the "PCP on Connexus" option under the Type drop down menu
- b. Enter ZIP code and Search

The search will bring up a list of PCP groups.

5.2.2 DME Providers

Find a preferred DME provider for savings on your DME:

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

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

SECTION 6. PRIOR AUTHORIZATION

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

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

6.1 PRIOR AUTHORIZATION REQUIREMENTS

When you use an out-of-network provider, you are responsible for making sure that your provider contacts us for prior authorization. If your services are not authorized in advance, we will not pay any benefits. You will have to pay the full charge. Any amounts that you have to pay because you did not get a prior authorization do not count toward your deductible or out-of-pocket maximum.

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

Prior authorization is not required for an emergency admission.

If your medication was not authorized in advance, we may authorize it retroactively.

6.1.1 Services Requiring Prior Authorization

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

- a. Inpatient services and residential programs
- b. Outpatient services
- c. Rehabilitation (physical, occupational, speech therapy)
- d. Diagnostic services, including imaging services
- e. Infusion therapy
- f. Disease management for pain
- g. Medications

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

6.1.2 Prior Authorization Limitations

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

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

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

6.1.3 Out-of-Network Services

If you cannot find an in-network provider or you need to transition your care to an in-network provider (see special circumstances in section 5.1.2), ask for prior authorization. When we cannot find an in-network provider for you, or while you are changing your care to an in-network provide, we may prior authorize your out-of-network care at the in-network benefit level.

When we authorize use of an out-of-network provider, you must make sure that the provider contacts Moda Health for prior authorization of any services that require it.

6.1.4 Second Opinion

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

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

SECTION 7. BENEFIT DESCRIPTION

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

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

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

7.1 WHEN BENEFITS ARE AVAILABLE

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

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

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

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

7.2 URGENT & EMERGENCY CARE

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

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

7.2.1 Ambulance Transportation

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

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

7.2.2 Emergency Room Care

All claims for emergency services (as defined in Section 12) will be paid at the in-network benefit level. Even when you use an in-network emergency room, some of the providers working in the emergency room and/or hospital may be out-of-network providers (see section 5.1.2 for more information). At an out-of-network emergency room, you cannot be balance billed unless permitted by law.

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

Prior authorization is not needed for emergency medical screening exams or treatment to stabilize an emergency medical condition. Let your PCP group know as soon as possible about any emergency care that you receive.

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

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

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

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

7.2.3 Inpatient Hospital Care Immediately Following an Emergency Room Visit

Inpatient care for an emergency medical condition includes both hospital and doctor charges for initial medical screening examination as well as medically necessary treatment which is immediately required to stabilize the member's condition. After care is provided for an emergency medical condition, the Plan must be contacted within 48 hours.

7.2.4 Inpatient Care Before the Member's Condition is Stabilized

When care is provided in a Tier III or Tier IV facility or by a Tier III or Tier IV provider, charges for inpatient care through stabilization will be payable at the Tier II facility benefit level and the Tier II provider benefit level if the care is approved by the Plan. When care is provided in an out-of-area facility, charges for inpatient care through stabilization will be payable at the Tier II benefit level.

7.2.5 Inpatient Care After the Member's Condition is Stabilized

Inpatient facility and provider charges incurred after your condition is stabilized are determined based on the *network status of the provider* and:

- a. After stabilization in a Tier III or Tier IV facility, if you elect to be transferred to a Tier I facility or a Tier II facility, then covered charges will be payable at the network facility

benefit level and network provider benefit level. Any transportation costs associated with this transfer will be subject to the Plan's review

- b. After stabilization in a Tier III or Tier IV facility, if you elect to continue to stay in a Tier III facility, then covered facility charges will be payable at the Tier III facility benefit level. If you elect to continue to stay in a Tier IV facility, then facility charges will not be covered. In addition:
 - i. if you elect to transfer care to a Tier II provider associated with the Tier II facility, then covered provider charges will be payable at the Tier II provider benefit level
 - ii. if you elect to continue to receive care from a Tier IV provider associated with the Tier IV facility, then covered provider charges will not be covered
- c. After stabilization in an out-of-area facility, if you elect to continue to stay in an out-of-area facility, then covered facility and provider charges will not be covered.
- d. If you are admitted to a Tier I facility, a Tier II or a Tier III facility and are under the care of a Tier IV provider, then covered facility charges will be payable at the Tier II facility benefit level.

Note: Your authorized representative may make on your behalf the elections referred to above.

7.2.6 Urgent Care

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

7.3 PREVENTIVE SERVICES

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

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

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

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

7.3.1 Colorectal Cancer Screening

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

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

With the exception of colonoscopy, screening tests involve 2 steps. If you have a positive result on a USPSTF-recommended screening covered under the preventive benefit, one follow-up colonoscopy to confirm the result of the original screening will also be covered under the preventive benefit as part of the screening procedure.

Anesthesia for colorectal cancer screening is covered under the preventive benefit. Anesthesia for your colonoscopy under the preventive benefit does not need prior authorization. All other anesthesia for colorectal cancer screening must be prior authorized.

These screening timelines apply to you if you are not at high risk for colorectal cancer. You may be screened earlier or more often if it is medically necessary. You are high risk if you have a family medical history of known genetic disorders that predispose you to a high lifetime risk of colorectal cancer (such as Lynch syndrome), you have had colorectal cancer or an adenomatous polyp before, or you have had inflammatory bowel disease. Screening exams and laboratory tests, including a follow-up colonoscopy to check progress of the original findings, are paid at the medical benefit level if you do not meet the criteria for the USPSTF A or B rated recommendation.

7.3.2 Contraception

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

7.3.3 Immunizations

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

7.3.4 Pediatric Screenings

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

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

7.3.5 Preventive Health Exams

Covered according to the following schedule:

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

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

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

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

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

7.3.7 Tobacco Cessation

The Plan covers counseling and interventions to prevent tobacco use and tobacco-caused disease. Covered expenses include counseling, office visits, medications and medical supplies.

7.3.8 Women's Healthcare

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

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

7.4 GENERAL TREATMENT SERVICES

All services must be medically necessary. Many outpatient services must be prior authorized. Some services may need a separate prior authorization. If your doctor does not get the required prior authorization, the charges will not be covered. You may have to pay the full cost. See section 6.1.1 for more information about prior authorization.

7.4.1 Acupuncture

The Plan covers acupuncture treatment up to an annual visit maximum when rendered by a licensed provider. Coverage does not include additional charges such as needles, suction cups or herbs.

7.4.2 Anticancer Medication

Prescribed anticancer medications, including oral, intravenous (IV) or injected medications, are covered. Most anticancer medications need to be prior authorized and have specific benefit limitations. You must get specialty anticancer medications from our designated specialty pharmacy (see section 7.6.4). For some anticancer medications, you may have to enroll in programs to help make sure the medication is used correctly and/or lower the cost of the medication. You can find more information on your Member Dashboard or by contacting Customer Service.

7.4.3 Applied Behavior Analysis (ABA)

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

Examples of what we do not cover:

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

7.4.4 Behavioral Health

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

Intensive outpatient mental health treatment and TMS must be prior authorized. Coordinated specialty programs must be prior authorized or authorized as soon as reasonably possible after you start them. See section 7.4.9 for coverage of diagnostic services.

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

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

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

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

Mental Health

These services by a mental health provider are covered:

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

Coordinated Specialty Programs

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

Coordinated specialty programs are:

- a. Early Assessment and Support Alliance (EASA) and Assertive Community Treatment (ACT) provided by Community Mental Health Programs
- b. Intensive Outpatient Services and Supports (IOSS)
- c. Intensive In-Home Behavioral Health Treatment (IBHT)

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

Substance Use Disorder Services

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

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

7.4.5 Child Abuse Medical Assessment

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

7.4.6 Clinical Trials

If you are enrolled in or participating in an approved clinical trial, usual care costs are covered. Usual care costs are medically necessary conventional care, items or services that are covered by the Plan if you get them outside of a clinical trial.

The Plan does not cover items or services:

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

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

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

7.4.7 Dental Injury

Dental services are not covered, except to treat accidental injury to your natural teeth, fractured jaw or for implants needed due to an accident injury. Natural teeth are teeth that grew in your mouth.

7.4.8 Diabetes Services

Insulin and diabetic supplies including insulin syringes, needles and lancets, test strips, glucometers and continuous glucose monitors are covered under the pharmacy benefit (section 7.6), when you buy them from a pharmacy with a valid prescription and using a preferred manufacturer (see the preferred drug list on your Member Dashboard). Insulin pumps may be covered under the DME benefit (section 7.4.11) if you do not get them from a pharmacy.

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

- a. HbA1c lab test
- b. Checking for kidney disease
- c. Annual dilated eye exam or retinal imaging, including one by an optometrist or ophthalmologist
- d. Diabetes self-management programs
 - i. One diabetes assessment and training program after you are diagnosed with diabetes
- e. Dietary or nutritional therapy
- f. Routine foot care (see section 7.4.28)

7.4.9 Diagnostic Procedures

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

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

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

7.4.10 Disease Management for Pain

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

7.4.11 Durable Medical Equipment (DME), Supplies & Appliances

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

Some examples of covered DME, supplies and appliances are:

- a. CPAP for sleep apnea
- b. Glasses or contact lenses, only if you have aphakia (missing lens) or keratoconus
- c. Hospital beds and accessories
- d. Insulin pumps, continuous glucose monitors and other diabetes supplies (see section 7.6 for coverage under Pharmacy benefit)
- e. Intraocular lenses within 90 days of cataract surgery
- f. Light boxes or light wands
- g. Orthotics, orthopedic braces, orthopedic shoes to restore or maintain your ability to do day to day activities or perform your job. If you can get the correction or support you need by modifying a mass-produced shoe, then we will only cover the cost of the modification.
- h. Oxygen and oxygen supplies
- i. Prosthetics
- j. Wheelchair or scooter (including maintenance expenses)

Diabetic supplies, other than insulin pumps and related supplies, are only covered when you get them from a pharmacy. You must have a prescription and use a preferred manufacturer (see section 7.6 for coverage under Pharmacy benefit).

The Plan covers the most cost effective alternative for DME, and either the rental or purchase of the equipment is covered based on the length of need and cost of the rental versus purchase. You can work with your providers to order your prescribed DME.

We encourage you to use a preferred DME provider. You may save money when you do. You can find a preferred provider using Find Care on your Member Dashboard (see section 5.2.2). Change

your recurring prescription or automated billing to a preferred DME provider by contacting your current provider and the preferred DME provider and asking for the change.

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

Exclusions

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

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

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

7.4.12 Gender Affirming Treatment

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

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

Covered services may include:

- a. Mental health
- b. Hormone therapy (including puberty suppression therapy for adolescents)
- c. Surgical procedures (see section 7.4.33) such as:
 - i. Breast/chest surgery
 - ii. Gonadectomy (hysterectomy/oophorectomy for FtM or orchiectomy for MtF)
 - iii. Single stage or multiple stage reconstruction of the genitalia
 - iv. Gender affirming facial surgery

If you cannot find an in-network provider for your gender-affirming care, contact Moda Health for help before going to an out-of-network provider. Out-of-network providers may balance bill you.

7.4.13 Hearing Services

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

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

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

We also cover:

- a. Ear molds and replacement ear molds when medically necessary, at least 4 times per year if you are under age 8 and once per year if you are age 8 to 25
- b. Initial batteries and one box of replacement batteries per year for each hearing aid if you are under age 26

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

For members age 26 and over, hearing aids and supplies are covered as noted in Section 3 every 3 years.

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

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

7.4.14 Home Healthcare

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

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

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

Home health visits have a calendar year maximum. Home health aides are not covered. If you are in hospice, your home healthcare, home care services and supplies are covered under sections 7.4.11 and 7.4.15.

7.4.15 Hospice Care

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

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

Hospice Home Care

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

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

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

Hospice Inpatient Care

Short term hospice inpatient services and supplies are covered.

Respite Care

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

Exclusions

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

- a. Hospice services provided to other than the terminally ill member
- b. Services and supplies that are not included in your hospice treatment plan or not specifically listed as a hospice benefit

7.4.16 Hospital Care

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

- a. Hospital room
- b. Intensive care unit
- c. Isolation care to protect you or other patients from spreading illness
- d. Facility charges for surgery performed in a hospital outpatient department

- e. Other hospital services and supplies when medically necessary for treatment and ordinarily provided by a hospital
- f. Take-home prescription medications are limited to a 3-day supply at the same benefit level as hospitalization

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

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

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

7.4.17 Hospital Visits

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

7.4.18 Inborn Errors of Metabolism

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

7.4.19 Infertility

The Plan covers office visits and diagnostic procedures related to diagnosis of infertility. (Treatment of infertility is not a covered benefit under the Plan).

7.4.20 Infusion Therapy

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

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

Your provider must get prior authorization for infusion therapy. You may have to use a preferred medication supplier, home infusion provider or provider office infusion for some medications. When we limit authorization to a certain supplier, provider or setting, medications you get from other suppliers or infusion therapy administered at a hospital outpatient facility or other in-network provider may not be covered. Some infusion medications from a preferred medication supplier are covered under the pharmacy specialty medication benefit (see Section 3 and section 7.6.3). See section 7.6.4 for self-administered infusion therapy. Some services and supplies are

not covered if your provider bills them separately. They are considered included in the cost of other billed charges.

7.4.21 Kidney Dialysis

Covered expenses include:

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

7.4.22 Massage Therapy

The Plan pays for the services of licensed massage therapists. Benefits are limited to an annual dollar maximum. To be covered, services must be within the scope of the massage therapists professional provider's license. Other services, such as office visits, lab and diagnostic x-rays, and physical therapy services are not covered under this benefit. They are paid under the Plan's standard in-network benefit for the type of service provided.

7.4.23 Maxillofacial Prosthetic Services

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

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

The problem must be because of:

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

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

7.4.24 Medication Administered by Provider, Treatment/Infusion Center or Home Infusion

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

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

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

See section 7.4.20 for more information about infusion therapy. Self-administered medications are not covered under this benefit (see section 7.6.4). See section 7.6 for pharmacy benefits.

7.4.25 Nonprescription Enteral Formula for Home Use

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

7.4.26 Nutritional Therapy

Dietary or nutritional therapy:

- a. Assessing your overall nutritional status
- b. Individualized diet and nutritional counseling

Preventive nutritional therapy required under the Affordable Care Act is covered at no cost to you:

- a. If you have a body mass index (BMI) 30 kg/m² or higher
- b. If you are overweight or obese and have cardiovascular disease risk factors
- c. For children age 6 years and older who are overweight or obese
- d. If you are female and age 40 to 60 with normal or overweight BMI, to maintain weight or limit weight gain

Also see diabetes services (section 7.4.8) and inborn errors of metabolism (section 7.4.18). Nutritional therapy does not include medical foods or nutritional supplements.

7.4.27 Office or Home Visits

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

7.4.28 Podiatry Services

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

7.4.29 Pre-admission Testing

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

7.4.30 Rehabilitation & Habilitation

Covered rehabilitative services are:

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

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

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

Outpatient rehabilitative services have an annual limit. The limit does not apply to medically necessary cardiac or pulmonary rehabilitation or services for behavioral health conditions. Prior authorization is required after 20 visits. A session can contain more than one type of therapy. Phase II cardiac rehabilitation is also covered under this Plan.

Rehabilitative services restore or improve an ability you have lost because of a medical condition. They are short term. Your condition is expected to improve in a reasonable and generally

predictable period of time. Therapy you get to prevent a condition or function from getting worse or to maintain a current level of functioning without documented improvement is maintenance therapy and is not covered. Recreational or educational therapy, educational testing or training, non-medical self-help or training, or animal therapy are not covered.

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

Nevertheless, the Plan covers services for neurodevelopmental disorders or developmental delays related to a neurogenic condition when such services are given to restore or improve a speech or body function, develop a speech or body function delayed by a neurogenic condition or maintain a speech or body function, when a neurogenic condition would cause significant deterioration in the member's condition without therapy.

7.4.31 Skilled Nursing Facility Care

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

Exclusions

These skilled nursing facility charges are not covered:

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

7.4.32 Spinal Manipulation

The Plan pays for the services of licensed chiropractors up to an annual visit maximum.

7.4.33 Surgery

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

The surgery cost sharing also applies to these services:

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

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

Bariatric Surgery/Gastric Bypass Surgery

The Plan will pay for bariatric surgery, including lap band, sleeve gastrectomy, and an open or laparoscopic Roux-en-y gastric bypass only. Bariatric Surgery or Gastric Bypass Surgery is subject to the prior authorization requirements of the Plan, up to the maximum plan allowance guidelines for the surgery, but **only** if:

- a. the surgery is performed at Salem Hospital;
- b. the surgery is pre-approved by following the prior authorization requirements and strict clinical criteria for this surgery is met. Examples of these criteria include, but may not be limited to: you must provide proof of attempts at weight management through non-surgical means.
- c. You are accepted by the Bariatric Surgery Program at *Salem Hospital* and follows their requirements. There is **no benefit** under the Choice Plan-MHP for any other program or any other facility;
- d. you qualify as “Morbidly Obese” or “Super Obese.”

In the event that you meet all clinical criteria of the Salem Hospital Bariatric Surgery Program, but the surgery cannot safely be performed at Salem Hospital, the Salem Hospital Bariatric Surgery Program may refer you to the Legacy Good Samaritan Weight Management Institute. In this case, the Plan will pay for bariatric surgery, including lap band, sleeve gastrectomy, and open or laparoscopic Roux-en-y gastric bypass only, subject to pre-authorization requirements, but only if:

- a. the surgery is pre-approved by following the pretreatment authorization requirements and strict clinical criteria for this surgery is met. Examples of these criteria include, but may not be limited to: you must provide proof of attempts at weight management through non-surgical means.
- b. you qualify as “Morbidly Obese” or “Super Obese.”
- c. you otherwise meet the criteria of the Bariatric Surgery Program at *Salem Hospital* and are referred by the program to the Legacy Good Samaritan Weight Management Institute; and
- d. the surgery is performed at Legacy Health.

There is **no benefit** under the Choice Plan-MHP for any other program or any other facility, or for any surgery performed without referral from the Salem Hospital Bariatric Surgery Program.

In no event shall the lifetime maximum benefit exceed \$90,000.00. Charges in excess of this maximum will not be covered under the Plan.

With respect to lap band procedures, the Plan will pay for up to 6 adjustments while not confined in a Hospital, over a period not to exceed 24 months. Adjustments or revisions in excess of 6 or beyond 24 months are not covered by the Plan.

“Morbidly Obese” means:

- a. having a Body Mass Index (BMI) greater than or equal to 40; or
- b. having a BMI greater than 35 when uncontrolled co-morbidities are present, such as hypertension, diabetes, etc.

“Super Obese” means having a Body Mass Index (BMI) greater than 50.

The Plan will pay for benefits for abdominal panniculectomy (skin removal after bariatric surgery), subject to the prior authorization requirements of the Plan. Charges for abdominal panniculectomy are not considered eligible out-of-pocket expenses.

Reversal or Revision of Bariatric Surgery/Gastric Bypass Surgery

The Plan may cover a revision of a previous bariatric surgical procedure or conversion to another medically necessary procedure due to inadequate weight loss as medically necessary when evaluated and prior authorized by the Plan and when the surgery is performed at Salem Hospital, or the Legacy Good Samaritan Weight Management Institute if referred by the Salem Hospital Bariatric Surgery Program.

The Plan will **not** cover a revision of a previous bariatric surgical procedure if inadequate weight loss is due to you:

- a. not complying with post-operative nutrition and exercise recommendations; or
- b. overeating, which causes a stretched stomach pouch.

The Plan may cover a surgical reversal of a previous bariatric surgical procedure as medically necessary when prior authorized by the Plan if you experience complications from the original surgery, (e.g., stricture or obstruction), as demonstrated on an upper GI test or upper endoscopy.

Cosmetic & Reconstructive

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

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

Surgery for breast enhancement, making breasts match, and replacing breast implants to change the shape or size of your breasts is not covered, except to treat gender dysphoria (see section 7.4.12) or after a mastectomy.

Reconstructive surgery after a medically necessary mastectomy includes:

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

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

7.4.34 Temporomandibular Joint Syndrome (TMJ)

TMJ treatment may be covered when:

- a. You have pain
- b. You cannot chew properly
- c. For severe acute trauma

Surgery and splints to treat TMJ must be prior authorized. There is a lifetime maximum on TMJ benefits. Treatment of related dental diseases or injuries is not covered.

7.4.35 Therapeutic Injections

Administrative services for therapeutic injections, such as allergy shots, are covered when you get them in a professional provider's office. When you can get similar results with self-administered medications at home, the administrative services for therapeutic injections by your provider are not covered. Vitamin and mineral injections are not covered unless they are medically necessary to treat a specific medical condition. More information is in sections 7.4.24 and 7.6.4.

7.4.36 Therapeutic Radiology

Covered expenses include:

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

7.4.37 Transplants

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

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

We cover transplant services that are approved by the Plan. We will direct you to the appropriate transplant facility for the specific type of transplant. In order to be covered, transplant services must be performed in exclusive transplant network facilities including a Salem Health Medical Group facility or a designated network facility. This section's requirements do not apply to corneal transplants and collecting and/or transfusing blood or blood products (see section 7.4.33).

Benefits for transplants are limited as follows:

- b. Donor costs are covered as follows:
 - i. If you are the recipient or self-donor, donor costs related to a covered transplant are covered. If the donor is also enrolled in the Plan, expenses resulting from complications and unforeseen effects of the donation are covered.
 - ii. If you are the donor and the recipient is not enrolled in the Plan, we will not pay any benefits toward donor costs.
 - iii. If the donor is not enrolled in the Plan, expenses that result from complications and unforeseen effects of the donation are not covered.
- c. Professional provider transplant services are paid according to the benefits for professional providers.

- d. Immunosuppressive medications you get during a hospital stay are paid as a medical supply. Outpatient oral and self-injectable prescription medications for transplant related services are paid under the Pharmacy Prescription benefit (section 7.6).
- e. We will not pay for chemotherapy with autologous or homogenic/allogenic bone marrow transplant for treatment of any type of cancer not approved for coverage.
- f. *Transplant travel benefit* - Charges for reasonable travel expenses incurred in connection with certain prior authorized transplants, other than corneal transplants, may be covered under the Plan subject to conditions and limitations. We must be notified before the travel benefit is utilized.

Definitions

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

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

7.4.38 Virtual Care Visits (Telemedicine)

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

A virtual care visit is covered if:

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

7.5 MATERNITY CARE

Pregnancy care, childbirth and related conditions are covered when you get the care from a professional provider. Midwives are not considered professional providers unless they are licensed or certified. Supportive services, such as physical, emotional and informational support to you before, during and after birth and during the postpartum period, are covered to a maximum dollar amount as required by OR SB 692, or under the newborn home visiting program (section 7.5.5).

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

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

7.5.1 Abortion

Abortions are covered at 100% when performed by an in-network provider.

7.5.2 Breastfeeding Support

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

7.5.3 Circumcision

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

7.5.4 Diagnostic Procedures

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

7.5.5 Newborn Home Visiting Program (Family Connects)

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

Services include:

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

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

7.5.6 Office, Home or Hospital Visits

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

7.5.7 Hospital Benefits

Covered hospital maternity care expenses are:

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

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

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

7.6 PHARMACY PRESCRIPTION BENEFIT

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

7.6.1 Covered Medication Supply

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

- a. A prescription medication that is medically necessary to treat a medical condition
- b. Compounded medications that have at least one covered medication as the main ingredient
- c. Insulin and diabetic supplies including insulin syringes, needles and lancets, test strips, glucometers and continuous glucose monitors. You must have a prescription and use a preferred manufacturer
- d. Certain prescribed preventive medications required under the Affordable Care Act
- e. Selected over the counter (OTC) products, including covered diabetic supplies, insulin, products containing pseudoephedrine, and Controlled Substance Schedule V medications, when accompanied with a valid prescription. The same benefit parameters such as cost sharing and days' supply restrictions will apply to covered OTC products. Additional information related to covered OTC products is available on the Member Dashboard or by contacting Customer Service.
- f. Medications to treat or prevent HIV are covered as required under the Affordable Care Act and Oregon statute. Preventive medications and services are at no cost to you
- g. Medications to treat tobacco dependence, including OTC nicotine patches, gum or lozenges. You must have a prescription. If you use an in-network retail pharmacy, they are covered with no cost to you as required under the Affordable Care Act
- h. Contraceptive medications and devices for birth control (section 7.3.2) and for medical conditions covered under the Plan. You can get up to a 3-month supply the first time you use the medication and up to a 12-month supply after that. Ask Customer Service how to get a 12-month supply.
- i. Certain immunizations and related administration fees are covered at no cost to you at in-network retail pharmacies (such as flu, pneumonia and shingles vaccines)

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

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

7.6.2 Mail Order Pharmacy

You can choose to fill prescriptions for covered medications and medicines through a Moda-designated mail order pharmacy, Postal Prescription Services (PPS) or Costco. Get a mail order pharmacy form from your Group, on your Member Dashboard or ask Customer Service.

7.6.3 Specialty Services & Pharmacy

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

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

7.6.4 Self-Administered Medication

All self-administered medications follow all of the prescription medication requirements of section 7.6. This includes specialty medication requirements (section 7.6.3) when you get a self-administered specialty medication. Self-administered injectable medications are not covered if you get them in a provider's office, clinic or facility.

7.6.5 Step Therapy

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

You or your professional provider can ask for a step therapy exception if:

- a. The Step 1 medication is ineffective, harmful, or you cannot tolerate it
- b. The Step 1 medication is not giving the same result as the requested Step 2 medication

Make the request through your Member Dashboard or by asking Customer Service. Include your professional provider's contact information. Your request must include information to support that it is medically necessary, including one of these:

- a. You tried the Step 1 medication using the right dose and for a long enough time, and it did not work for you
- b. You were not able to tolerate the Step 1 medication, or it was not effective for you
- c. The Step 1 medication is expected to be harmful to you or not give the same results as the medication you are asking for, based on your condition
- d. You tried a Step 2 medication for at least 90 days and had a positive outcome. Changing to the Step 1 medication is expected to be harmful or not give the same result.

We will contact your professional provider to find out how the medication is being used in your treatment plan. Step therapy exceptions must be based on medical necessity and generally accepted medical practice. We will make a decision about your exception request within 72 hours – or just 24 hours if your request is urgent. This exception process is not used for a medication or pharmacy charge that is not covered for other reasons, such as generic substitution, plan limitations or exclusions.

7.6.6 Limitations

- a. New FDA approved medications will be reviewed. We may have coverage requirements or limits. You or your prescriber can ask for a medical necessity evaluation if we do not cover a newly approved medication during the review period.
- b. If you get a brand medication when a generic equivalent is available, you will have to pay the difference in cost between the generic and brand medication. These additional costs do not count toward your out-of-pocket maximum.
- c. We may prior authorize certain brand medications for a specific amount of time or until a generic medication becomes available, whichever comes first. When a generic medication becomes available during the authorized period, the brand medication is no longer covered. You can get the generic medication without a new prescription or authorization.
- d. You may not bypass the Plan's requirements (such as step therapy, prior authorization) by starting treatment with a medication, whether by using free samples or otherwise.
- e. Some specialty medications may be limited to a 2-week supply.
- f. Medications with dosing intervals greater than the Plan's maximum day supply will have an increased copayment to match the day supply.
- g. Medications you buy outside the United States and its territories are only covered in emergency and urgent care situations.
- h. You may ask to have your medication refilled early if you are going to travel outside of the United States. When we allow an early refill, it is limited to once every 6 months. You cannot get an early refill to extend your medication supply beyond the end of the plan year.
- i. If you need an emergency refill of insulin or diabetic supplies, we will cover it no more than 3 times per year. We will only cover the smallest available package or a 30-day supply, whichever is less.

7.6.7 Exclusions

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

- a. **Devices.** Including, but not limited to therapeutic devices and appliances. Information for contraceptive devices is in section 7.6.1 and for other devices in section 7.4.11
- b. **Foreign Medication Claims.** Medications you buy from non-U.S. mail order or online pharmacies or U.S. mail or online pharmacies acting as agents of non-U.S. pharmacies
- c. **Hair Growth Medications.**
- d. **Immunization Agents for Travel.** Except as required under the Affordable Care Act
- e. **Institutional Medications.** To be taken by or administered while you are a patient in a hospital, rest home, skilled nursing facility, extended care facility, nursing home or similar institution
- f. **Medication Administration.** A charge to administer or inject a medication, except for immunizations or contraceptives at in-network retail pharmacies
- g. **Medications Covered Under Another Benefit.** Such as medications covered under home health, medical, etc.

- h. **Medications Not Approved by FDA.** Products not recognized or designated as FDA approved medications. This includes medications that are found to be less than effective by the FDA's Drug Efficacy Study Implementation (DESI) classifications.
- i. **Non-Covered Condition.** A medication prescribed for reasons other than to treat a covered medical condition
- j. **Nutritional Supplements and Medical Foods.**
- k. **Off-label Use.** Medications prescribed for or used for non-FDA approved indications, unless Oregon's Health Evidence Review Commission or Pharmacy Therapeutics and Review Committee has approved it
- l. **Over the Counter (OTC) Medications** which do not require a prescription in Oregon and prescription medications for which there is an OTC equivalent or alternative, except for contraceptives or those treating tobacco dependence. Select OTC products are included within your benefit.
- m. **Pharmacies excluded from the network.** Medications from pharmacies that are not allowed to contract with the network. This includes pharmacies that have been excluded from the network for non-compliance with fraud, waste and abuse laws.
- n. **Repackaged Medications.**
- o. **Replacement Medications and/or Supplies.**
- p. **Vitamins and Minerals.** Except as required by law
- q. **Weight Loss Medications.**

7.6.8 Definitions

ArrayRx is a collaboration developed by Washington and Oregon to coordinate their programs and resources to lower prescription costs. For more information, see arrayrxsolutions.com.

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

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

Generic Medications are medications that have been found by the Food and Drug Administration (FDA) to be therapeutically equivalent to the brand option and will often save you money. Generic medications must have the same active ingredients as the brand version and be identical in strength, dosage form and the way you take them.

In-network Pharmacy is a pharmacy that is contracted under ArrayRx Core Network to provide prescription medication benefits to you.

Nonpreferred Tier Medications are brand medications, including specialty brand medications, that we have reviewed and they do not have significant therapeutic advantage over their preferred alternative(s). These medications generally have safe and effective options available under the Value, Select and/or Preferred tiers.

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

Preferred Tier Medications are medications, including specialty preferred medications, that we have reviewed and found to be safe and effective at a better price compared to other medications in the same therapeutic class and/or category. Generic medications that have not

been shown to be safer or more effective than other more cost effective generic medications are included in this tier.

Prescription Medication List Our Moda Health Prescription Medication List is on your Member Dashboard. It gives you information about how commonly prescribed medications are covered. Not every covered medication is on the list. We will review new medications and may set coverage limitations.

What tier a medication is in may change and will be updated from time to time. Use the prescription price check tool on your Member Dashboard to get the latest information. Ask Customer Service if you have any questions.

Prescribing and dispensing decisions are to be made by your professional provider and pharmacist using their expert judgment. Talk with your professional providers about whether a medication from the list is appropriate for you. This list is not meant to replace your professional provider's judgment when deciding what medication to prescribe to you. Moda Health and the Plan are not responsible for any prescribing or dispensing decisions.

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

Select Tier Medications are the most cost effective options in their therapeutic category. This tier includes generic and certain brand medications, including specialty medications, that are safe, effective and cost effective.

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

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

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

SECTION 8. GENERAL EXCLUSIONS

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

Benefits Not Stated

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

Biofeedback

Care Outside the United States

Except for care that is due to an urgent or emergency medical condition

Charges Over the Maximum Plan Allowance

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

Chelation Therapy

Except to treat heavy metal poisoning.

Correctional Services

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

Cosmetic Procedures

Any procedure or medication with the main purpose of changing or maintaining your appearance and that will not result in significant improvement in body function. Examples include hormone treatment, rhinoplasty, breast enhancement, liposuction and hair removal. Reconstructive or gender affirming surgery is covered if medically necessary and not specifically excluded (see section 7.4.33).

Custodial Care

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

Dental Examinations and Treatment; Orthodontia

Except services described in sections 7.4.7 and 7.4.23, or if medically necessary to restore function due to craniofacial irregularity

Educational Supplies and Services

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

- a. Books, tapes, pamphlets, subscriptions, videos and computer programs (software)

- b. Psychoanalysis or psychotherapy as part of a training or educational program, regardless of your diagnosis or symptoms
- c. Educational services provided by a school, including a boarding school
- d. Level 0.5 education-only programs

Experimental or Investigational Procedures

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

Faith Healing**Family Planning**

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

Food Services

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

Home Birth or Delivery**Homeopathic Treatment and Supplies****Illegal Acts**

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

Infertility

Except as provided in section 7.4.19.

Inmates

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

Naturopathic Supplies

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

Never Events

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

Non-Therapeutic Counseling

Including legal, financial, vocational, spiritual and pastoral counseling

Nuclear Radiation

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

Obesity or Weight Reduction

Except as provided for in section 7.4.33

Orthopedic Shoes

Except as described in section 7.4.11

Orthognathic Surgery

Including associated services and supplies

Personal Items

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

Physical Exercise Programs

Programs, videos and exercise equipment

Private Nursing Services**Professional Athletic Activities**

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

Reports and Records

Including charges for completing claim forms or treatment plans

Routine Foot Care

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

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

Self-Administered Medications

Including oral and self-injectable when you get them directly from a physician's office, facility or clinic instead of through the pharmacy prescription medication or anticancer benefits (sections 7.6.4 and 7.4.2).

Self-Improvement Programs

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

Service Related Conditions

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

Services for Administrative or Qualification Purposes

Physical or mental examinations, psychological testing and evaluations and related services for purposes such as employment or licensing, participating in sports or other activities, insurance coverage, or deciding legal rights, administrative awards or benefits, or corrections or social service placement. The only exception is as specifically described in section 7.4.5

Services Not Provided

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

Services Otherwise Available

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

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

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

Services Provided or Ordered by a Family Member

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

Services Provided by Volunteer Workers**Sexual Dysfunction of Organic Origin**

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

Support Groups

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

Taxes, Fees and Interest

Except as required by law

Telehealth

Except telemedicine as specifically described in section 7.4.38

Therapies

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

Third Party Liability Claims

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

Transportation

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

Treatment in the Absence of Illness

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

Treatment After Coverage Ends

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

Treatment Before Coverage Begins

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

Treatment Not Medically Necessary

Including services or supplies that do not meet our medical necessity criteria or are:

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

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

Vision Care

Including eye exams, the fitting, provision or replacement of eyeglasses or contact lenses, and any charges for orthoptics, vitamin therapy, low vision therapy, eye exercises or fundus photography, except where specifically covered under the Plan. See section 7.4.8 for coverage of annual dilated eye exam to manage diabetes.

Vision Surgery

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

Vitamins and Minerals

Except as required by law.

Wigs, Toupees, Hair Transplants**Work Related Conditions**

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

SECTION 9. CLAIMS ADMINISTRATION & PAYMENT

9.1 SUBMISSION & PAYMENT OF CLAIMS

What to know about sending us a claim:

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

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

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

9.1.1 How to Send Us Claims

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

Include all of the following information:

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

Some claims will require additional information:

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

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

9.1.2 Prescription Medication Claims

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

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

9.1.3 Explanation of Benefits (EOB)

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

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

9.1.4 Claim Inquiries

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

9.1.5 Time Frames for Processing Claims

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

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

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

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

9.2 APPEALS & EXTERNAL REVIEW

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

9.2.1 Time Limit for Submitting Appeals

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

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

You can fill out an appeal form (in your Member Dashboard under Resources), or send us a letter including all the identifying information from the appeal form (see “If I am not satisfied...” in Section 13). Describe what happened and what outcome you are hoping for. Include medical records or other documentation that will help us investigate your appeal.

9.2.2 The Review Process

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

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

How First and Second Level Appeals Work

- a. Submit your appeal in writing, on time. If you need help, ask Customer Service
- b. Someone who was not involved in the original decision will investigate your appeal
- c. We will send the decision to you within 15 days of a pre-service appeal or 30 days of a post-service appeal

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

Expedited Appeals

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

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

Special Circumstance

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

The timelines for reviewing your appeal do not apply if:

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

You must go through the first and second levels of appeal before you can sue under ERISA section 502(a). You may lose the right to sue if you have not used all of your internal appeal rights. The only exception is if we do not meet the timelines for review or provide all of the information and notices required under state and federal law.

9.2.3 External Review

You must complete the appeal process described in section 9.2.2 before you can ask for external review unless the Plan agrees to skip the appeal process, or if we have not met the internal timeline for review or the federal requirements for providing related information and notices.

Only certain types of denials are eligible for external review. You may ask to have your appeal reviewed by an independent review organization (IRO) if it relates to:

- a. Rescission of coverage (section 13.2)
- b. An adverse determination based on medical judgment (this may include medical necessity, appropriateness, healthcare setting, level of care or effectiveness of a covered benefit, or whether a treatment is experimental or investigational)
- c. Whether surprise billing protections apply to an adverse benefit determination

How external review works:

- a. Your request for external review must be in writing to the Appeals Department (see section 2.1) no more than 4 months after you receive the adverse benefit determination or the final internal adverse benefit determination
- b. If the appeal is about a condition for which you received emergency services and are still hospitalized, your request for external review may be expedited or at the same time as a request for internal appeal review
- c. If your request is incomplete or is not eligible for external review, we will tell you in writing no more than 6 business days after we receive the request. Otherwise, the IRO will send you its decision no more than 45 days after it receives the request. If your appeal is about urgent care, the IRO will do an expedited review. They will give you their decision no more than 72 hours after they receive the request. The decision of the IRO is binding, except to the extent other remedies are available to you under state or federal law.

9.2.4 Definitions

For purposes of section 9.2, the following definitions apply:

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

- a. Rescission of coverage (section 13.2)
- b. Eligibility to participate in the Plan
- c. Network exclusion, annual benefit limit or other limitation on otherwise covered services
- d. Utilization review (described below)
- e. Limitations or exclusions described in Section 7 or Section 8, including a decision that an item or service is experimental or investigational or not medically necessary

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

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

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

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

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

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

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

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

9.3 CONTINUITY OF CARE

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

If you are under the care of a particular provider when their contract with us ends, you should get a letter from us or the provider group telling you about your right to continuity of care.

Continuity of care is not automatic. You must request continuity of care from us. Your provider must agree to follow the requirements of their most recent medical services contract with us, and to accept the contractual reimbursement applicable at the time the contract ended

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

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

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

- a. The day after you finish the treatment or are no longer diagnosed with the condition that triggered your right to continuity of care
- b. 90 days after the date you were told the contract with your provider had ended

Continuity of care is not available if:

- a. You leave the Plan
- b. The Group ends the Plan
- c. The provider cannot continue to care for patients

9.4 BENEFITS AVAILABLE FROM OTHER SOURCES

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

9.4.1 Coordination of Benefits (COB)

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

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

9.4.1.1 When this Plan Pays First

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

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

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

9.4.1.2 How COB Works

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

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

- a. We will calculate the benefits we would have paid if you did not have any other healthcare coverage. We will apply that amount to any allowable expense that the primary plan did not pay
- b. We will credit any amount to the deductible that would have been applied if you did not have other coverage

- c. We will reduce the benefits we pay so that payments from all plans are not more than 100% of the total allowable expense
- d. If the primary plan did not cover an expense because you did not follow that plan's rules, we will not cover that expense either. An example is if your primary plan did not cover an expense because you did not get prior authorization when it was required

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

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

9.4.1.3 Definitions

For purposes of section 9.4.1, the following definitions apply:

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

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

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

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

Plan does not include:

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

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

These are not allowable expenses:

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

9.4.2 Coordination with Medicare

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

9.4.3 Third Party Liability

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

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

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

- a. If we pay claims that are, or are alleged to be, the responsibility of a third party, you hold any rights of recovery against the third party in trust for the Plan.
- b. The Plan is entitled to be reimbursed for any benefits we pay out of any recovery from a third party if there is a settlement or judgment against the third party. This is so whether or not the third party admits liability or claims that you are also at fault. The Plan is entitled to receive the amount of benefits it has paid whether the health care expenses are itemized or expressly excluded in the third party recovery.
- c. The Plan is not responsible for and will not pay any fees or costs (such as attorney fees) associated with your pursuing a claim against a third party. Neither the "made-whole" rule nor the "common-fund doctrine" rule applies. If the Plan is exempt from ERISA, a proportionate share of reasonable attorney fees may be subtracted from our recovery.
- d. Even without your written authorization, we may release to, or obtain from, any other insurer, organization or person, any information we need to carry out the provisions of section 9.4.3.
- e. If it is reasonable to expect that you will have future expenses for which the Plan might pay benefits, you will seek recovery of such future expenses in any third party claim.
- f. Section 9.4.3 applies to you if the Plan advances benefits whether or not the event causing your injuries occurred before you became covered by Moda Health.

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

9.4.3.1 Motor Vehicle Accident Recovery

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

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

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

9.4.4 Surrogacy

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

SECTION 10. ELIGIBILITY & ENROLLMENT

Please see separate Summary Plan Description furnished by the Group for information regarding eligibility and enrollment or contact the Human Resources Department.

SECTION 11. CONTINUATION OF HEALTH COVERAGE

Please see separate Summary Plan Description furnished by the Group for information regarding Continuation of Coverage or contact the Human Resources Department.

SECTION 12. DEFINITIONS

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

Authorization see Prior Authorization.

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

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

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

Coinsurance is a percentage of covered expense that you pay. If your coinsurance is 20%, you pay 20% of the covered charge and we pay the other 80%.

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

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

Covered dependent means a person who is within the class of eligible dependents as set forth in the Summary Plan Description booklet furnished by the Group and has applied to and been accepted by the Group.

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

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

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

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

Dependent is any person who is or may become eligible for coverage because of a relationship to a subscriber as set forth in the Summary Plan Description booklet furnished by the Group.

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

- a. **Registered Domestic Partner** is a person joined with the subscriber in a partnership that has been registered under the laws of any federal, state or local government
- b. **Unregistered Domestic Partner** is a person who has entered into a partnership with the subscriber that meets the Group's eligibility criteria

Eligible Employee is any employee or former employee of the Group who meets the eligibility requirements as set forth in the Summary Plan Description booklet furnished by the Group.

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

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

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

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

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

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

- a. Involve a treatment for which scientific or medical assessment has not been completed, or the effectiveness of the treatment has not been generally established. This includes a

treatment program that may be proven for some uses, but scientific literature does not support the use as requested or prescribed. An example is a medication that is proven as a treatment when used alone, but scientific literature does not support using it in combination with other therapies.

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

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

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

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

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

Implant is a material inserted or grafted into tissue.

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

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

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

MPA for out-of-network services is either a supplemental provider fee arrangement we may have in place or the amount calculated using any one of the following methods: a percentage of the Medicare allowable amount, a percentage of the allowable amount established by the Oregon Health Authority, a percentile of fees commonly charged for a given procedure in a given area, a percentage of the acquisition cost or a percentage of the billed charge.

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

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

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

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

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

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

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

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

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

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

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

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

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

- a. Board-certified psychiatrist
- b. Psychologist or psychologist associate
- c. Psychiatric mental health nurse practitioner
- d. Clinical social worker, mental health counselor or marriage and family therapist

- e. A program licensed, approved, established, maintained, contracted with or operated by the Oregon Office of Mental Health & Addiction Services
- f. An associate or resident in the field of counseling, marriage and family therapy, social work or psychology who is practicing under a board-approved supervision plan and working for a provider who is contracted and credentialed with Moda Health

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

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

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

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

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

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

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

Prior Authorization or **Prior Authorized** refers to getting approval from us before the date of service. A complete list of services and medications that require prior authorization is available on your Member Dashboard or you can ask Customer Service. A service, supply or medication that is not prior authorized when required will not be covered (see section 6.1).

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

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

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

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

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

SECTION 13. GENERAL PROVISIONS & LEGAL NOTICES

13.1 MEMBER DISCLOSURES

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

You have the right to:

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

You have the responsibility to:

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

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

Will someone tell me if my PCP is no longer participating in the network?

If your PCP ends their participation in the network, we will tell you and give you instructions on how to change your PCP group.

What if I have a medical emergency?

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

You do not need to contact your PCP before you get emergency treatment. You should contact your PCP as soon as reasonably possible afterward. You are covered anywhere in the world for medical emergency treatment. More information is in section 7.2.

How will I know if my benefits change or end?

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

What are the prior authorization and utilization review criteria?

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

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

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

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

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

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

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

We protect your information in several ways:

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

If I am not satisfied with the plan, how can I file an appeal?

You can file an appeal by writing a letter to Moda Health. Include the following information:

- a. Member name and date of birth
- b. Subscriber ID number
- c. Contact information (phone, email, mailing address)
- d. Provider(s) involved

- e. Date(s) of service
- f. Medical records from the provider, if applicable
- g. Reason for appeal/complaint
- h. Description of what happened
- i. Desired outcome

Customer Service can help you if needed. Complete information about the appeal process is in section 9.2.

You may also contact the Employee Benefits Security Administration at 206-757-6781 about your appeal rights or for other assistance.

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

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

What is provider risk sharing?

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

13.2 GENERAL & MISCELLANEOUS PROVISIONS

Contract Provisions

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

Confidentiality of Member Information

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

Right to Collect & Release Needed Information

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

Transfer of Benefits

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

Correction of Payments or Recovery of Benefits

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

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

Warranties

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

No Waiver

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

Group is the Agent

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

Responsibility for Quality of Medical Care

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

Compliance with Federal & State Mandates

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

Governing Law

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

Where any Legal Action Must be Filed

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

Time Limit for Filing a Lawsuit

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

Evaluation of New Technology

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

Replacing Another Plan

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

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

Notices

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

Rescission

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

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

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

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

13.3 ERISA DUTIES

Subscribers are entitled to certain rights and protections if the Plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA). Ask the Group if this section applies to your Plan.

Plan Administrator as Defined Under ERISA

Moda Health is not the plan administrator or the named fiduciary of the Plan, as defined under ERISA. Contact the Group for more information.

Information about the Plan and Benefits

Subscribers may examine all documents governing the Plan. This includes insurance contracts, collective bargaining agreements, updated summary plan description, and the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor. This information can be obtained by written request. You will not be charged, except the Group may charge a reasonable amount for the copies. Subscribers are entitled to receive a summary of the Plan's annual financial report, if any is required by ERISA.

Continuation of Group Health Plan Coverage

Subscribers are entitled to continue healthcare coverage for themselves or their dependents if they lose coverage under the Plan because of a qualifying event. You may have to pay for such coverage. Review this handbook and the documents governing the Plan for information about the rules governing your continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for members, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate the Plan, called fiduciaries of the Plan, have a duty to do so prudently and in the interest of members. No one, including the employer or any other person, may fire or discriminate against a subscriber in any way to prevent them from obtaining a benefit or exercising rights under ERISA.

Enforcement of Rights

If a claim for benefits is denied or no action is taken, in whole or in part, you have a right to receive an explanation, to obtain without charge copies of documents relating to the decision, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce these rights. For instance, if you ask the Group for a copy of plan documents or the latest annual report and do not receive it within 30 days, you may file suit in federal court. The court may require the Group to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Group. If a claim for benefits is denied or no action is taken, you may file suit in state or federal court after you have exhausted the Plan's appeal process (see section 9.2). In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court.

If plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or may file suit in federal court. The court will decide who should pay court costs and legal fees. If you are successful, the

court may order the person you sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, (e.g., if it finds the claim is frivolous).

Assistance with Questions

For questions about this section or your rights under ERISA, or for help obtaining documents from the Group, contact one of the following:

Employee Benefits Security Administration

Seattle District Office, 300 Fifth Ave., Ste. 1110, Seattle WA, 98104

Phone 206-757-6781

Information and assistance is also available through their website: dol.gov/agencies/ebsa

Office of Outreach, Education and Assistance, U.S. Department of Labor

200 Constitution Ave. NW, DC 20210

Phone 866-444-3272

You may call them to obtain publications about your rights and responsibilities under ERISA

Nondiscrimination notice

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

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

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

If you need any of the above, call:

888-217-2363 (TDD/TTY 711)

If you think we did not offer these services or discriminated, you can file a written complaint.

Please mail or fax it to:

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

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

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

U.S. Department of Health
and Human Services
200 Independence Ave. SW, Room 509F
HHH Building, Washington, DC 20201
800-368-1019, 800-537-7697 (TDD)

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

Scott White coordinates our nondiscrimination work:

Scott White,
Compliance Officer
601 SW Second Ave.
Portland, OR 97204
855-232-9111
compliance@modahealth.com

modahealth.com

ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-877-605-3229 (TTY: 711) or speak to your provider.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-877-605-3229 (TTY: 711) o hable con su proveedor.

LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số (Người khuyết tật: 1-877-605-3229 (TTY: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.

주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-877-605-3229 (TTY: 711) 번으로 전화하거나 서비스 제공업체에 문의하십시오.

ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-877-605-3229 (TTY: 711) или обратитесь к своему поставщику услуг.

注：日本語を話される場合、無料の言語支援サービスをご利用いただけます。アクセシブル（誰もが利用できるよう配慮された）な形式で情報を提供するための適切な補助支援やサービスも無料をご利用いただけます。1-877-605-3229 (TTY: 711) までお電話ください。または、ご利用の事業者にご相談ください。

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzen zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-877-605-3229 (TTY: 711) an oder sprechen Sie mit Ihrem Provider.

PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-877-605-3229 (TTY: 711) o makipag-usap sa iyong provider.

УВАГА: Якщо ви розмовляєте українська мова, вам доступні безкоштовні мовні послуги. Відповідні допоміжні засоби та послуги для надання інформації у доступних форматах також доступні безкоштовно. Зателефонуйте за номером 1-877-605-3229 (TTY: 711) або зверніться до свого постачальника».

ማሳሰቢያ፡- አማርኛ የሚናገሩ ከሆነ፣ የቋንቋ ድጋፍ አገልግሎት በነፃ ይቀርብልዎታል። መረጃን በተደራሽ ቅርጸት ለማቅረብ ተገቢ የሆኑ ተጨማሪ እገዛዎች እና አገልግሎቶች እንዲሁ በነፃ ይገኛሉ። በስልክ ቁጥር 1-877-605-3229 (TTY: 711) ይደውሉ ወይም አገልግሎት አቅራቢዎን ያናግሩ።

FIIRO GAAR AH: Haddaad ku hadasho Soomaali, adeegyo kaalmada luuqadda ah oo bilaash ah ayaad heli kartaa. Qalab caawinaad iyo adeegyo oo habboon si loogu bixiyo macluumaadka qaabab la adeegsan karo ayaa sidoo kale bilaa lacag heli karaa. Wac 1-877-605-3229 (TTY: 711) ama la hadal bixiyahaaga.

ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-877-605-3229 (TTY: 711) ou parlez à votre fournisseur.

注意：如果您说[中文]，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电（文本电话：1-877-605-3229 (TTY: 711)）或咨询您的服务提供商。

ເລີ່ມຊາບ: ຖ້າທ່ານເວົ້າພາສາ ລາວ, ລະມືບໍລິການຊ່ວຍດ້ານພາສາແບບບໍ່ເສຍຄ່າໃຫ້ທ່ານ. ມີເລື່ອງຊ່ວຍ ແລະ ການບໍລິການແບບບໍ່ເສຍຄ່າທີ່ເໝາະສົມເພື່ອໃຫ້ຂໍ້ມູນໃນຮູບແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້. ໂທຫາຕີ 1-877-605-3229 (TTY: 711) ຫຼື ລົມກັບຜູ້ໃຫ້ບໍລິການຂອງທ່ານ.

หมายเหตุ: หากคุณใช้ภาษาไทย เรามีบริการความช่วยเหลือด้านภาษาฟรี นอกจากนี้ ยังมีเครื่องมือและบริการช่วยเหลือเพื่อให้ข้อมูลในรูปแบบที่เข้าถึงได้โดยไม่เสียค่าใช้จ่าย โปรดโทรติดต่อ 1-877-605-3229 (TTY: 711) หรือปรึกษาผู้ให้บริการของคุณ

توجه دین: اگر آپ اردو بولتے ہیں، تو آپ کے لیے زبان کی مفت مدد کی خدمات دستیاب ہیں۔ قابل رسائی فارمیٹس میں معلومات فراہم کرنے کے لیے مناسب معاون امداد اور خدمات بھی مفت دستیاب ہیں۔ - (1-877-605-3229 (TTY: 711) پر کال کریں یا اپنے فراہم کنندہ سے بات کریں۔"

LUS CEEV TSHWJ XEEB: Yog hais tias koj hais Lus Hmoob muaj cov kev pab cuam txhais lus pub dawb rau koj. Cov kev pab thiab cov kev pab cuam ntxiv uas tsim nyog txhawm rau muab lus qhia paub ua cov hom ntaub ntauv uas tuaj yeem nkag cuag tau rau los kuj yeej tseem muaj pab dawb tsis xam tus nqi dab tsi ib yam nkaus. Hu rau 1-877-605-3229 (TTY: 711) los sis sib tham nrog koj tus kws muab kev saib xyuas kho mob.

सावधान: यदि तपाईं नेपाली भाषा बोल्नुहुन्छ भने तपाईंका लागि निःशुल्क भाषिक सहायता सेवाहरू उपलब्ध छन्। पहुँचयोग्य ढाँचाहरूमा जानकारी प्रदान गर्न उपयुक्त सहायता र सेवाहरू पनि निःशुल्क उपलब्ध छन्। 1-877-605-3229 (TTY: 711) मा फोन गर्नुहोस् वा आफ्नो प्रदायकसँग कुरा गर्नुहोस्।

ശ്രദ്ധിക്കുക: നിങ്ങളുടെ മലയാളം ഭാഷ സംസാരിക്കുമെങ്കിൽ, സൗജന്യ ഭാഷാ സഹായ സേവകങ്ങൾ നിങ്ങൾക്ക് ലഭ്യമാണ്. ആകസ്മിച്ച് ചെയ്യാവുന്ന ഫോർമാറ്റുകളിൽ വിവരങ്ങൾ നൽകാനുള്ള ഉചിതമായ അനുബന്ധ സഹായങ്ങളും സേവനങ്ങളും കൂടെ സൗജന്യമായി ലഭ്യമാണ്. 1-877-605-3229 (TTY: 711) ലേക്ക് വിളിക്കുക അല്ലെങ്കിൽ നിങ്ങളുടെ ദാതാവിനോട് സംസാരിക്കുക.

PANANGIKASO: No agsasaoka iti Ilocano, magun-odmo dagiti libre a serbisio ti tulong iti pagsasao. Libre met laeng a magun-odan dagiti maitutop a katulongan ken serbisio a mangipaay iti impormasion kadagiti ma-akses a pormat. Awagan ti 1-877-605-3229 (TTY: 711) wenno makisarita iti mangipapaay kenka.

ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 1-877-605-3229 (TTY: 711) पर काल करें या अपने प्रदाता से बात करें।

సావధానం: మీరు తెలుగు మాట్లాడితే, మీకు ఉచిత భాషా సహాయ సేవలు అందుబాటులో ఉంటాయి. యాక్సెస్ చేయగల ఫార్మాట్లలో సమాచారాన్ని అందించడానికి తగిన సహాయక సహాయాలు మరియు సేవలు కూడా ఉచితంగా అందుబాటులో ఉంటాయి. 1-877-605-3229 (TTY: 711) కి కాల్ చేయండి లేదా మీ ప్రొవైడర్‌తో మాట్లాడండి.

تنبيه: إذا كنت تتحدث اللغة العربية، فستوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 877-605-3229 (TTY: 711) أو تحدث إلى مقدم الخدمة."

AKIYESI: Ti o ba so Yorùbá, awon isẹ iranlowo ede ofe wa fun o. Awon iranlowo iranlowo ti o ye ati awon isẹ lati pese alaye ni awon ona kika wiwole tun wa laisi idiyele. Pe 1-877-605-3229 (TTY: 711) tabi soro si olupese re.

MAKINIKA: Ikiwa wewe huzungumza Kiswahili, msaada na huduma za lugha bila malipo unapatikana kwako. Vifaa vya usaidizi vinavyofaa na huduma bila malipo ili kutoa taarifa katika mifumo inayofikiwa pia inapatikana bila malipo. Piga simu 1-877-605-3229 (TTY: 711) au zungumza na mtoa huduma wako.

ATENÇÃO: Se você fala Português do Brasil, serviços gratuitos de assistência linguística estão disponíveis para você. Auxílios e serviços auxiliares apropriados para fornecer informações em formatos acessíveis também estão disponíveis gratuitamente. Ligue para 1-877-605-3229 (TTY: 711) ou fale com seu provedor.



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