Washington Group Medical Plan

Prime 1000

Effective date: January 1, 2014

Health coverage provided by
Moda Health Plan, Inc.
601 SW Second Avenue
Portland, Oregon 97204

SCHEDULE OF BENEFITS

This schedule is a quick reference summarizing the Plan's benefits. The details of the actual benefits and the conditions, limitations and exclusions are contained in the member handbook.

All "annual" or "per year" benefits accrue on a calendar year basis unless otherwise specified.

	In-Network Benefits	**Out-Of-Network Benefits**
Annual Deductible Per Member	**$1,000**	**$2,000**
Annual Deductible Per Family	**$2,000**	**$4,000**
Annual Out-of-Pocket Maximum Per Member (includes deductible)	**$3,000**	**$6,000**
Annual Out-of-Pocket Maximum Per Family (includes deductible)	**$6,000**	**$12,000**

Services	**Cost Sharing** (Amount Member Pays. Deductible applies unless noted differently.)		**Section in Handbook & Details**
	In-network	**Out-of-network**	
Emergency Care			In-network out-of-pocket maximum apply to mental health & substance use disorder services.
Ambulance Transportation			Section 5.2
(Mental Health & Substance Use Disorder)	$150 per visit (no deductible)	$150 per visit (no deductible)	
(Non Mental Health & Substance Use Disorder)	20%	20%	
Emergency Room Facility	$150 (no deductible)	$150 (no deductible)	Section 5.3 and 5.4.2 Copay waived if covered hospitalization immediately follows emergency room use.
Urgent Care			Section 5.6.9
(Mental Health & Substance Use Disorder)	$75 per visit (no deductible)	$75 per visit (no deductible)	
(Non Mental Health & Substance Use Disorder)	$75 per visit (no deductible)	40%	

Services	Cost Sharing (Amount Member Pays. Deductible applies unless noted differently.)		Section in Handbook & Details
	In-network	**Out-of-network**	
Hospital and Residential Facility Care			
Dental Procedures Facility Charges	20%	40%	Section 5.4.1
Detoxification for Substance Use Disorder	20%	40%	Section 5.4.5 Prior authorization not required for medically necessary detoxification.
Inpatient Acute Care	20%	40%	Section 5.4.3
Inpatient Rehabilitation	20%	40%	Section 5.4.4 Subject to a combined 60 day limit with skilled nursing facility care per year
Residential Mental Health & Substance Use Disorder Treatment Programs	20%	40%	Section 5.4.6
Skilled Nursing Facility Care	20%	40%	Section 5.4.7 Subject to a combined 60 day limit with inpatient rehabilitation facility per year
Ambulatory Services			
Diagnostic Procedures, X-ray and Lab	No cost sharing	40%	Section 5.5.1
Imaging Procedures	20%	40%	Section 5.5.2
Infusion Therapy	20%	40%	Section 5.5.3
Kidney Dialysis	20%	40%	Section 5.5.7
Outpatient Rehabilitation (Includes Neurodevelopment Therapy)	$25 (no deductible)	40%	Section 5.5.4 Up 20 visits of physical therapy, 20 visits of occupational therapy, 20 visits of speech therapy, 24 visits of manipulative treatment, 20 visits of massage therapy, 20 visits of pulmonary rehabilitation therapy, 36 visits of cardiac rehabilitation therapy and 30 visits of post-cochlear implant aural therapy per year

Services	**Cost Sharing** (Amount Member Pays. Deductible applies unless noted differently.)		**Section in Handbook & Details**
	In-network	**Out-of-network**	
Outpatient Substance Use Disorder Services	$25 (no deductible)	40%	Section 5.5.5
Outpatient Surgery and Invasive Diagnostic Procedures (Facility Charges)	20%	40%	Section 5.5.6
Therapeutic X-ray	20%	40%	Section 5.5.7
Professional Services			
Acupuncture Services	$25 (no deductible)	40%	Section 5.6.1 10 visits per year
Contraceptive Services & Devices			Section 5.6.3
Women's contraception	No cost sharing	40%	
Others	20%	40%	
Dental Care	20%	40%	Section 5.6.5 $5,000 lifetime maximum for implants
Diabetes Services	$25 (no deductible)	40%	Section 5.6.6
Hearing Aids	20%	40%	Section 5.6.7 $5,000 per year
Mental Health Services	$25 (no deductible)	40%	Section 5.6.8
Office Visits			Section 5.6.9
Primary care visits	$25 (no deductible)	40%	
Routine Vision Exam	$25 (no deductible)	Not covered	One per year
Specialist visits	$25 (no deductible)	40%	
Physician Hospital Visits	20%	40%	Section 5.6.9

Services	**Cost Sharing** (Amount Member Pays. Deductible applies unless noted differently.)		**Section in Handbook & Details**
	In-network	**Out-of-network**	
Preventive Healthcare			Section 5.6.11
Services as recommended under the Affordable Care Act, including the following:	No cost sharing	Not covered, unless otherwise stated	Recommended age limits and frequency limits apply. Refer to federal website www.healthcare.gov/what-are-my-preventive-care-benefits/ for info
Periodic Health Exams	No cost sharing	Not covered	
Immunizations	No cost sharing	Not covered	
Newborn Hearing Screening	No cost sharing	Not covered	
Routine Vision Screening	No cost sharing	Not covered	
Women's Annual Exam & Pap Test	No cost sharing	Not covered	
Routine Mammogram	No cost sharing	Not covered	
Routine Colonoscopy	No cost sharing	Not covered	
Other Preventive Services including			
Prostate Rectal Exam	$25 (no deductible)	Not covered	One per year, age 50+
Prostate Specific Antigen (PSA) Test	No cost sharing	40%	One per year, age 50+
Routine Diagnostic X-ray & Lab	No cost sharing	Not covered	
Surgery	20%	40%	Section 5.6.14
Therapeutic Injections	20%	40%	Section 5.6.15
Other Services			
Biofeedback	20%	40%	Section 5.7.1 10 visits per lifetime
Breastfeeding Support, Supplies and Counseling	No cost sharing	No cost sharing	Section 5.7.2
Home Healthcare	20%	40%	Section 5.7.3 130 visits per year

Services	**Cost Sharing** (Amount Member Pays. Deductible applies unless noted differently.)		**Section in Handbook & Details**
	In-network	**Out-of-network**	
Hospice Care			Section 5.7.4
Home Care	20%	40%	
Inpatient Care	20%	40%	
Respite Care	20%	40%	
Maternity	Treated same as any other condition	Treated same as any other condition	Section 5.7.5
Medical Foods for PKU	20%	40%	Section 5.7.6
Orthotic Devices	20%	40%	Section 5.7.7
Outpatient Durable Medical Equipment	20%	40%	Section 5.7.7 One wheelchair per year under age 19 and every 3 years age 19+
Prosthetic Devices	20%	40%	Section 5.7.7
Supplies and Appliances	20%	40%	Section 5.7.7
Transplants			Section 5.7.8
Exclusive transplant network facilities	20%	N/A	
Other facilities	40%	40%	
Prescription Drugs			See separate Schedule of Benefits

MEMBER HANDBOOK

INTRODUCTION

This member handbook is part of the policy between Moda Health and the Group to provide benefits to members. The most current handbook is also available on myModa, accessed through the Moda Health website. All plan provisions are governed by the Group's policy with Moda Health. This member handbook may be changed or replaced from time to time, by the Group or Moda Health, without the consent of any member.

In addition to this handbook the Policy includes:

- The Group Policy;
- The Schedule of Benefits;
- The Group Application;
- Amendments.

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SECTION 1. SUMMARY OF BENEFITS

This section is a quick reference summarizing the Plan's benefits. The details of the actual benefits and the conditions, limitations and exclusions are contained in the sections that follow.

The Plan does not require referrals before members can access any professional provider, including those providing women's health care services. Section 2 provides information regarding prior authorization requirements. Members can review a complete list of procedures and supplies that require prior authorization in Exhibit A of this member handbook. Failure to obtain required prior authorizations will result in denial of benefits or a penalty.

1.1 MEMBER RESOURCES

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

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

Medical Customer Service Department
Toll-Free 855-294-1668; Llamado Gratis 888-786-7461

Pharmacy Customer Service Department
Toll-Free-855-294-1669

Moda Behavioral Health
Toll-free 800-799-9391

Telecommunications Relay Service for the hearing impaired
711

1.2 MEMBERSHIP CARD

After enrolling, members will receive identification cards that will include the identification number. Members will need to present the card each time they receive services.

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

1.3 NETWORK INFORMATION

In-network benefits apply to services delivered by in-network providers; out-of-network benefits apply to services delivered by out-of-network providers. By using an in-network provider, members will receive quality healthcare and will have a higher level of benefits. Members may choose an in-network provider by using "Find Care" on myModa or by contacting Customer Service for assistance. Member ID cards will identify the applicable networks.

Emergency services are always paid at the in-network benefit level.

Primary Network; Primary Service Area
All members have access to a primary network, which provides services in their primary service area. Primary service area includes all counties in Washington as well as Idaho and Oregon. Additional networks may also be available to members if the subscriber resides outside the primary service area. Subscribers who move outside of a network service area must contact Customer Service to find out if another network is available to ensure continued access to in-network providers.

Networks
For all members:
First Choice Health PPO Network in Washington
ODS Plus Network in Idaho and Oregon
Pharmacy Network is Northwest Prescription Drug Consortium

For members if subscribers reside outside the First Choice Health and ODS Plus Network service area, they may access the networks listed below and receive the in-network level of benefits only if the subscriber resides outside the First Choice Health and ODS Plus Network service area. Members who reside in the First Choice Health and ODS Plus Network service area will receive out-of-network benefits when using any of the other networks listed above:

ODS Select Network with service area Alaska
Private HealthCare Systems (PHCS) with service area nationwide

1.4 COVERAGE OUTSIDE THE PRIMARY SERVICE AREA FOR CHILDREN

Enrolled children residing outside the primary service area may receive the in-network benefit level by using a travel network provider as described in section 1.5. If a travel network provider is not available, plan benefits will be extended to such children as if the care were rendered by in-network providers, subject to the following limitations:

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

1.5 TRAVEL NETWORK

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

Travel Network
Healthy Directions Network

Members may choose a travel network provider by using "Find Care" on myModa or by contacting Customer Service for assistance.

1.6 SCHEDULE OF BENEFITS

The information is included in the document named Schedule of Benefits.

1.7 DEDUCTIBLES

The Plan has annual deductibles as shown in the Schedule of Benefits. The deductible is the amount of covered expenses that are paid by each member before benefits are payable. The deductible applies separately to each member, but no family will be required to satisfy more than the total family deductible, no matter how many members are in the family. After the deductible has been satisfied, benefits will be paid according to the Schedule of Benefits.

Copayments, prescription drug out-of-pocket expenses, and disallowed charges do not apply toward the annual deductible.

If covered expenses are incurred in the last 3 months of a calendar year and applied toward the deductible for that year, they will be carried forward and applied toward the deductible for the following year.

If the Plan replaces a group policy of the Group, any deductible amount satisfied under the prior policy during the year will be credited.

Deductibles are accumulated on a calendar year basis. If the Plan renews on a date other than January 1st, members may be liable for additional deductible after renewal through December 31st.

1.8 ANNUAL MAXIMUM OUT-OF-POCKET

The annual out-of-pocket maximum is the member's cost sharing for all covered services and supplies described in this handbook. After the annual per member or per family out-of-pocket maximum is met, the Plan will pay 100% of covered services for the remainder of the year. The in-network and out-of-network out-of-pocket maximums accumulate separately and are not combined.

Out-of-pocket costs are accumulated on a calendar year basis. If the Plan renews on a date other than January 1st, members may be liable for additional out-of-pocket costs after renewal through December 31st.

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

a. Cost containment penalties
b. Out-of-pocket expenses for transplants performed out-of-network
c. Disallowed charges

1.9 PAYMENT

Expenses allowed by Moda Health are based upon the maximum plan allowance, which is a contracted fee for in-network providers and for out-of-network providers is an amount established, reviewed, and updated by a national database.

Except for cost sharing and policy benefit limitations, in-network providers agree to look solely to Moda Health, if it is the paying health carrier, for compensation of covered services provided to members. Nothing in this paragraph shall prohibit a provider and a member from entering into an agreement for payment by the member for medical services that are not covered by the Plan.

1.10 CARE AFTER NORMAL OFFICE HOURS

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

SECTION 2. COST CONTAINMENT

The following special cost containment provisions may affect how benefits are paid.

2.1 PRIOR AUTHORIZATION REQUIREMENTS

When a professional provider suggests admission to the hospital or a residential program, or a non-emergency surgery, the member should ask the provider to contact Moda Health for prior authorization. A list of services and supplies that require prior authorization is in Exhibit A of this handbook.

Moda Health will review prior authorization requests for procedures and supplies and notify the outcome to the hospital, professional provider and member under the following timelines:

a. One business day for extension of concurrent care or if the member needs immediate treatment and any delay will result in an emergency room visit or emergency admission
b. 48 hours for urgent care
c. 5 calendar days for planned non-urgent care
d. 20 business days for treatment that is experimental or investigational
e. 30 calendar days for procedures and supplies already provided

If additional information is needed to complete the review, the notice of delay will describe the information needed and the party responsible for providing the additional information will have 45 days to submit it. Once the additional information is received, a determination notice will be provided as soon as reasonably possible to accommodate the timelines listed above.

If a member fails to obtain prior authorization for prescription drugs, inpatient or residential stays, or for outpatient or ambulatory services when authorization is required (other than advanced imaging procedures), a penalty of 50% up to a maximum deduction of $2,500 per occurrence will be applied to covered charges before regular plan benefits are computed. The member will be responsible for any charges not covered because of noncompliance with authorization requirements.

If prior authorization is not obtained for advanced imaging services for members utilizing all networks other than PHCS and Healthy Directions, the charges will be denied.

In-network providers who perform the imaging services are responsible for obtaining prior authorization on the member's behalf. Members using an out-of-network provider are responsible for ensuring that their provider contacts Moda Health for prior authorization. Services not authorized in advance will be denied. The in-network provider is expected to write off the full charge of the service. If the provider is out-of-network, the full charge will be the member's responsibility.

Except in the case of fraud or misrepresentation, prior authorization for medical necessity shall be binding if obtained no more than 30 calendar days prior to the date the service is provided, and eligibility shall be binding for 3 business days from the date of the authorization.

A member may obtain authorization information by contacting Customer Service, or for mental health or substance abuse disorder services by contacting Moda Behavioral Health.

2.1.1 Inpatient Services and Residential Programs

All non-emergency hospital confinements that are scheduled in advance, and admission to any residential treatment program, must be prior authorized in order for maximum plan benefits to be payable except when a member is involuntarily committed. If the hospital or residential stay is not medically necessary, claims will be denied. Moda Health will authorize medically necessary lengths of stay, based upon the medical condition. Additional hospital or residential days are covered only upon medical evidence of need.

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

2.1.2 Ambulatory Surgery and Other Outpatient Services

The Plan requires prior authorization for many outpatient services. Certain diagnostic and therapeutic procedures can be performed without an inpatient admission or overnight stay in a hospital. Prior authorization must be obtained for any inpatient admission or overnight stay for a service that is commonly performed on an outpatient basis. Some outpatient or ambulatory services also require prior authorization. Any covered benefit will be based on the cost of the most appropriate setting for the procedure.

2.1.3 Prescription Drugs

The member, provider or pharmacy should contact Customer Service for prior authorization.

2.2 COST EFFECTIVE SERVICES

Cost effectiveness services are services or supplies that are not otherwise benefits of the Plan, but which Moda Health believes to be medically necessary, cost effective and beneficial for quality of care. Moda Health works with a member and his or her professional provider to consider effective alternatives to hospitalization and other care to make more efficient use of the Plan's benefits. After case management evaluation and analysis by Moda Health, cost effective services agreed upon by the member, the professional provider and Moda Health will be covered. Any party can also provide notification in writing and terminate such services.

The fact that the Plan has paid benefits for cost effectiveness services for a member shall not obligate it to pay such benefits for any other member, nor shall it obligate the Plan to pay benefits for continued or additional cost effectiveness services for the same member unless agreed upon by Moda Health, the member and the professional provider. All amounts paid for cost effectiveness services under this provision shall be included in computing any benefits, limitations, copayments or coinsurance under the Plan.

SECTION 3. CARE COORDINATION

3.1 CARE COORDINATION

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

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

3.2 DISEASE MANAGEMENT

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

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

Toll-free number 800-592-8283

Office Hours – Monday through Friday
7:00 AM to 5:30 PM (Pacific Time)

SECTION 4. DEFINITIONS

The following are definitions of some important terms used in this member handbook.

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

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

Authorization see Prior Authorization.

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

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

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

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

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

Creditable Coverage means a member's prior healthcare coverage under any of the following:

a. A group health plan
b. Individual insurance coverage including student health plans and short-term limited duration insurance
c. Medicare Part A and B
d. Medicaid, other than benefits consisting solely of benefits under Section 1928 (pediatric vaccines)
e. Tricare
f. A medical care program of the Indian Health Service or of a tribal organization
g. A State high risk pool
h. Federal Employees Health Benefit Plan (FEHBP)
i. A public health plan (as defined in regulations)
j. Children's Health Insurance Program (CHIP)
k. A health benefits plan under Section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e))

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

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

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

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

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

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

Domestic Partner means a person joined with the subscriber in a partnership that has been registered according to the state requirements in Washington or in any other state.

Eligible Employee means any employee or former employee who has met the eligibility requirements to be enrolled under the Plan.

Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition (a) placing the health of the person, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy (b) serious impairment to bodily functions or (c) serious dysfunction of any bodily organ or part.

Emergency Medical Screening Examination means the medical history, examination, ancillary tests and medical determinations required to ascertain the nature and extent of an emergency medical condition.

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

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

Enrolled Dependent means a subscriber's eligible dependent whose application has been accepted by the Group and who is enrolled in the Plan.

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

Exclusion Period means a period during which specified treatments or services are excluded from coverage.

Experimental or investigation means those services and supplies that:

a. Are not provided by an accredited institution or provider within the United States or by one that has not demonstrated medical proficiency in the provision of the service or supplies
b. Are not recognized by the medical community in the service area in which they are received
c. Involve a treatment for which the approval of one or more government agencies is required, but has not been obtained at the time the services and supplies are rendered or are to be rendered
d. Involve a treatment for which scientific or medical assessment has not been completed, or the effectiveness of the treatment has not been generally established
e. Are available in the United States only as part of clinical trial or research program for the illness or condition being treated except for routine costs of certain clinical trials (see section 5.5.8)

The **Group** refers to a trust organized under the laws of the state of Washington for the purpose of representing and serving the interests of its Participating Employers who employ a combined minimum of eligible employees who are enrolled according to the requirements of the policy.

Group Eligibility Waiting Period means the period of employment with the Participating Employer that a prospective member must complete before coverage begins.

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

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

Implant means a material inserted or grafted into tissue.

Injury means a personal bodily injury to a member caused solely by external, violent and accidental means.

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

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

MPA for an out-of-network provider other than a facility is the lesser of supplemental provider fee arrangements Moda Health may have in place and the 75th percentile of fees commonly charged for a given procedure in a given area, based on a national database. If a dollar value is not available in the national database, Moda Health will consider 75% of the billed charge as the MPA. In certain instances, when a dollar value is not available in the database, the claim is reviewed by Moda Health's medical consultant, who determines a comparable code to the one billed. Once a comparable code is established, the claim is processed as described above.

MPA for out-of-network facilities, including hospitals, ambulatory surgical centers, home health providers, skilled nursing facilities, residential mental health or substance use disorder treatment programs, hospice, end-stage renal disease (ERSD) facilities or long-term care facilities is the lesser of supplemental facility or provider fee arrangements Moda Health may have in place, 125% of the Medicare allowable amount based on data collected from the Centers for Medicare and Medicaid Services (CMS), or the billed charge.

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

MPA for implanted medical devices is the contracted amount, or the acquisition cost of the device plus 10% if there is no contracted amount.

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

When using an out-of-network provider, any amount above the MPA is the member's responsibility.

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

Medically Necessary means those services and supplies that are required for diagnosis or treatment of illness or injury and which are:

a. Appropriate and consistent with the symptoms or diagnosis of the member's condition
b. Established as the standard treatment by the medical community in the service area in which they are received
c. Not primarily for the convenience of the member or a provider
d. The least costly of the alternative supplies or levels of service that can be safely provided to the member. This means, for example, that care rendered in a hospital inpatient setting is not medically necessary if it could have been provided in a less expensive setting, such as a skilled nursing facility or by a nurse in the member's home, without harm to the member.

Medically necessary care does not include custodial care.

Member means a subscriber, dependent of a subscriber or a person otherwise eligible for a group health benefit plan who has enrolled for coverage under the terms of the Plan.

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

Mental Health Provider means a board-certified psychiatrist, or any state-licensed professionals including a psychologist, a psychologist associate, a practicing mental health nurse practitioner, an advanced practice psychiatric nurse, a clinical social worker, a professional counselor, a mental health counselor, or a marriage and family therapist.

Mental Health Services means medically necessary outpatient and inpatient services provided to treat mental disorders covered by the diagnostic categories listed in the most current version of the diagnostic and statistical manual of mental disorders, published by the American psychiatric association, on July 24, 2005, or such subsequent date as may be provided by the insurance commissioner by rule, consistent with the purposes of chapter 6, Laws of 2005, with the exception of the following categories, codes, and services: (a) Substance related disorders; (b) life transition problems, currently referred to as "V" codes, and diagnostic codes 302 through 302.9 as found in the diagnostic and statistical manual of mental disorders, 4th edition, published by the American psychiatric association; (c) skilled nursing facility services, home health care, residential treatment, and custodial care; and (d) court ordered treatment unless Moda Health's medical director or designee determines the treatment to be medically necessary

Moda Health refers to Moda Health Plan, Inc.

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

Network Service Area is the geographical area where the in-network providers provide their services. In Washington, network service area includes all counties.

Out-of-Network Providers refers to providers that have not contracted under Moda Health to provide benefits to members.

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

Participating Employer refers to an individual employer that:

a. is considered an active member company of the Group;
b. has met the eligibility and enrollment guidelines as required by the Group; and
c. is actively engaged in business which employs eligible employees who are enrolled according to the requirements of the policy.

The **Plan** is the health benefit plan sponsored by the Group and provided under the terms of the policy between the Group and Moda Health.

The **Policy** is the agreement between the Group and Moda Health for covering the health benefit plan sponsored by the Group. This member handbook is a part of the policy.

Prior Authorization or **Prior Authorized** refers to obtaining approval by Moda Health prior to the date of service. A complete list of services and drugs that require prior authorization is available on myModa or by contacting Customer Service. Failure to obtain required authorization will result in denial of benefits or a penalty (see section 2.1).

Professional Provider means any individual who is duly licensed under Title 18 RCW to provide medically necessary services within the scope of their licenses. In all cases, the services must be covered under the Plan to be eligible for benefits. Examples of professional providers include:

a. Acupuncturist
b. Audiologist
c. Chiropractor
d. Dentist (doctor of medical dentistry or doctor of dental surgery)
e. Denturist
f. Mental health provider as defined above
g. Naturopath
h. Nurse practitioner

i. Optometrist
j. Physician (doctor of medicine or osteopathy)
k. Physician assistant
l. Podiatrist
m. Registered nurse or licensed practical nurse
n. Registered nurse first assistant
o. Registered physical, occupational, or speech therapist
p. Women's healthcare provider rendering women's healthcare services including maternity care, reproductive health services, gynecological care, general examination and medically necessary preventive care and follow-up visits

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

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

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

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

Substance Use Disorder means an illness characterized by a physiological or psychological dependency, or both, on a controlled substance regulated under chapter 69.50 RCW and/or alcoholic beverages. It is further characterized by a frequent or intense pattern of pathological use to the extent the user exhibits a loss of self-control over the amount and circumstances of use; develops symptoms of tolerance or physiological and/or psychological withdrawal if use of the controlled substance or alcoholic beverage is reduced or discontinued; and the user's health is substantially impaired or endangered or his or her social or economic function is substantially disrupted.

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

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

Waiting Period means the period that must pass before a person is eligible to enroll for benefits under the terms of the Plan.

SECTION 5. BENEFIT DESCRIPTION

The Plan covers services and supplies listed when medically necessary for diagnosis and/or treatment of a medical condition. Payment of covered expenses is always limited to the maximum plan allowance. Some benefits have day or dollar limits. These limits are found in the "Details" column in the Schedule of Benefits.

Many services require prior authorization. A complete list is in Exhibit A of this member handbook. Failure to obtain required prior authorization will result in denial of benefits or a penalty (see section 2.1).

5.1 WHEN BENEFITS ARE AVAILABLE

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

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

If a member is in the hospital or any other facility, including a skilled nursing facility, on the day coverage ends, Moda Health will only pay for those covered services and supplies rendered before coverage ends.

5.2 AMBULANCE TRANSPORTATION

Ambulance transportation, including local ground transportation by state certified ambulance and certified air ambulance transportation, and treatment provided as part of the ambulance service is covered for medically necessary transport to the nearest facility that has the capability to provide the necessary treatment. Services provided by a stretcher car, wheelchair car or other similar methods are considered custodial and are not covered benefits.

5.3 EMERGENCY CARE

Members are covered for treatment of emergency medical conditions worldwide. A member who believes he or she has a medical emergency should call 9-1-1 or seek care from the nearest appropriate provider, such as a physician's office or clinic, urgent care facility or emergency room. All emergency services will be reimbursed at the in-network benefit level. However, out-of-network providers may bill members for charges in excess of the maximum plan allowance.

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

5.4 HOSPITAL & RESIDENTIAL FACILITY CARE

All hospital and residential facility care require prior authorization. A hospital is a facility that is licensed as an acute care hospital and that provides inpatient surgical and medical care to members who are acutely ill. Its services must be under the supervision of a staff of licensed physicians and must include 24-hour-a-day nursing service by registered nurses. Facilities that are primarily rest, old age or convalescent homes are not considered to be hospitals. The Plan will cover expenses incurred in facilities operated by the federal government where benefit payment is mandated by law.

5.4.1 Dental Procedures Facility Charges

The Plan covers general anesthesia services and related facility charges in conjunction with the dental procedure performed in a hospital or ambulatory surgical center if medically necessary for members who meet one of the following criteria:

a. Under age of 9
b. Physically or developmentally disabled regardless of age
c. With a medical condition that his or her physician determines would place the member at undue risk if the dental procedure were performed in a dental office

5.4.2 Emergency Room Care

The Plan covers medically necessary emergency room based services, supplies and treatment including professional charges, facility costs, prescription drugs, and outpatient charges for patient observation and medical screening exams required to stabilize a patient with an emergency medical condition. See section 5.3 for more information.

5.4.3 Hospital Benefits

The Plan allows benefits for acute hospital care including:

a. Hospital room. The actual daily charge, not to exceed the hospital's most common rate for a 2-bed room
b. Isolation care
c. Intensive care unit
d. Facility charges including those for surgery and kidney dialysis performed in a hospital outpatient department
e. Other hospital services and supplies necessary for treatment and ordinarily furnished by a hospital, including provider and staff services and treatments delivered during an inpatient hospital stay and inpatient pharmacy services

f. Newborn care including one in-nursery physician's visit and nursery services and supplies when the newborn is eligible and enrolled
g. 3-day supply of take home prescription drugs

In lieu of hospitalization or other institutional expenses, the Plan covers substitution of home health care furnished by home health, hospice or home care agencies licensed under chapter 70.127 RCW that can provide care in the most appropriate and cost effective setting. Substitution of care will be authorized with the consent of the member and recommendation of his or her attending physician.

5.4.4 Inpatient Rehabilitative Hospital Care

Covered rehabilitative care expenses, including facility and professional services, are subject to an annual limit for skilled nursing facility and inpatient services delivered in a hospital or other inpatient rehabilitation facility that specializes in such care. Additional days may be available for treatment required following head or spinal cord injury, subject to medical necessity and prior authorization. These benefits are payable only when a member's condition requires inpatient rehabilitative hospital care.

For members age 6 and under, neurodevelopment therapy benefits shall be payable for services for the maintenance of a member in cases where significant deterioration in the member's condition would result without the service. Benefits are also payable to restore and improve function.

In order to be a covered expense, rehabilitative services must begin within one year of the onset of the condition from which the need for services arises and must be part of a physician's formal written program to improve and restore lost function following illness or injury. The services must be appropriate to the condition that is being treated.

5.4.5 Substance Use Disorder Detoxification Program

All-inclusive per diem charge for room and treatment services by a treatment program that meets the definitions in the Plan are covered. Medically necessary detoxification is covered as an emergency medical condition and no prior authorization is required.

5.4.6 Residential Mental Health and Substance Use Disorder Treatment Programs (Include Day Treatment and Partial Hospitalization)

All-inclusive per diem charges for mental health and/or substance use disorder treatment programs, including prescription drugs, providing no less than 4 hours per day of direct treatment services are covered.

5.4.7 Skilled Nursing Facility

Covered skilled nursing facility days are subject to a combined annual limit with inpatient rehabilitation services and medical necessity. Skilled nursing facility costs, including services by mental health providers for a covered diagnosis, other professional services, and pharmacy services and prescriptions filled in the skilled nursing facility pharmacy, are covered. Room and board is limited to the average semi-private room rate.

5.5 AMBULATORY SERVICES

Many ambulatory services require prior authorization. A complete list is in Exhibit A of this member handbook. Failure to obtain required prior authorization will result in denial of benefits or a penalty.

5.5.1 Diagnostic Procedures, Radiology and Laboratory Services

The Plan covers diagnostic procedures, x-rays and laboratory tests related to treatment of a medical condition.

a. Diagnostic procedures including mammography and prostate screening services and colonoscopies not covered in section 5.6.12, cardiovascular testing, pulmonary function studies and neurology/neuromuscular procedures
b. Diagnostic radiology services including x-ray and ultrasound imaging
c. Diagnostic laboratory services, supplies and tests, including genetic testing

5.5.2 Imaging Procedures

The Plan covers all standard imaging procedures related to treatment of a medical condition (see section 2.1).

5.5.3 Infusion Therapy

The Plan covers outpatient and home infusion therapy services and supplies when prior authorized and ordered by a professional provider as a part of an infusion therapy regimen.

5.5.4 Outpatient Rehabilitation

Rehabilitative services and covered neurodevelopment therapy provided by a professional provider to a member who is not confined in a hospital are subject to different annual limits. Medically necessary outpatient services for mental health and substance use disorder are not subject to these limits.

Rehabilitative services are physical, occupational, speech or massage therapies medically necessary to restore or improve lost function caused by a medical condition. Outpatient rehabilitative services are short term in nature with the expectation that the member's condition will improve significantly in a reasonable and generally predictable period of time.

A session is one visit. No more than one session of each type of physical, occupational, or speech therapy is covered in one day.

Therapy performed to maintain a current level of functioning without documentation of significant improvement is considered maintenance therapy and is not covered. Maintenance programs that prevent regression of a condition or function are not covered. This benefit does not cover recreational or educational therapy, educational testing or training, non-medical self-help or training or hippotherapy. Nevertheless, for members age 6 and under, benefits shall be payable for services for the maintenance of a member in cases where significant deterioration in the member's condition would result without the service. Benefits are also payable to restore and improve function.

5.5.5 Outpatient Substance Use Disorder Services

Services for assessment and treatment of substance use disorder in an outpatient treatment program are covered. Moda Behavioral Health can help members locate in-network providers and understand their benefits.

5.5.6 Outpatient Surgery

The Plan covers facility costs, surgical supplies, anesthesiology, and other services ordinarily provided by a hospital or surgical center.

5.5.7 Radium, Radioisotopic, X-ray Therapy, and Kidney Dialysis

Covered expenses include:

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

5.5.8 Routine Costs in Clinical Trials

Routine costs for the care of a member who is enrolled in or participating in a qualified clinical trial are covered. Routine costs mean items and services that are consistent with and typically provided absent a clinical trial. Such costs will be subject to the applicable cost sharing if provided in the absence of a clinical trial. The Plan is not liable for any adverse effects of a clinical trial.

Qualified clinical trials are phase I, phase II, phase III or phase IV clinical trials that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening medical condition and:

a. Funded, or supported by a center or cooperative group that is funded by the National Institutes of Health (NIH), the Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, the Centers for Medicare and Medicaid Services, the United States Department of Defense, the United States Department of Veterans Affairs or the United States Department of Energy
b. Funded or approved by an NIH cooperative group or center which is a formal network of facilities that collaborate on research projects and have an established NIH-approved peer review program operating with the group including the National Cancer Institute (NCI) Clinical Cooperative Group and Community Clinical Oncology Program
c. Conducted as an investigational new drug application reviewed by the United States Food and Drug Administration
d. Exempt by federal law from the requirement to submit an investigational new drug application to the United States Food and Drug Administration
e. Funded or approved by an institutional review board of an institution in Washington that has a multiple project assurance contract approval by the Office of Protection for the Research Risks of the NIH
f. Funded or approved by a qualified research entity that meets the criteria for NIH Center Support Grant eligibility

The Plan does not cover:

a. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis
b. Items or services that are provided solely to satisfy data collection and analysis needs
c. Items and services that are not used in the direct clinical management of the member
d. The investigational item, device or service itself

5.6 PROFESSIONAL PROVIDER SERVICES

5.6.1 Acupuncture Care

The Plan pays for acupuncture care up to an annual limit except such limit does not apply to treatment for substance use disorder.

5.6.2 Cochlear Implants

Cochlear implants are covered when determined medically necessary and prior authorized.

5.6.3 Contraception

Contraceptive services and devices include, but not limited to, vasectomy, tubal ligation, FDA approved contraceptive methods (including removal of devices) and counseling are covered when prescribed by a professional provider. Office visits and consultations related to contraception are also covered. Women's contraception, when delivered by an in-network provider and utilizing the most cost effective option (i.e., generic instead of brand name), will be covered at no cost sharing.

5.6.4 Cosmetic and Reconstructive Surgery

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

Cosmetic surgery is not covered. Reconstructive procedures that are partially cosmetic in nature may be covered if the procedure is medically necessary. All reconstructive procedures and treatment for complications must be medically necessary and prior authorized.

Surgery for breast augmentation, achieving breast symmetry, and replacing breast implants (prosthetics) to accomplish an alteration in breast contour or size are not covered, except as provided in section 5.6.12.

5.6.5 Dental Care

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

a. The accidental injury must have been caused by a foreign object or was caused by acute trauma (e.g., a broken tooth resulting from biting and/or chewing is not an accidental injury)
b. Diagnosis is made within 6 months of the date of injury
c. Treatment is medically necessary and is provided by a physician or dentist while the member is enrolled in the Plan

The Plan only covers treatment within 12 months of the date of injury. Covered treatment is limited to that which will restore teeth to a functional state. Implants and implant related services under this provision are subject to a per member lifetime maximum.

5.6.6 Diabetes Services

The Plan covers services for diabetic self-management training and education, including nutrition therapy when ordered and provided by a professional provider with expertise in diabetes. Benefits also include medical eye examinations (dilated retinal examinations) and preventive foot care for members with diabetes. Related supplies and appliances are covered under section 5.7.7 and 5.9.

5.6.7 Hearing Aids

Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. The Plan covers one hearing aid per hearing impaired ear up to an annual limit. Members must be examined by a physician before obtaining a hearing aid that is prescribed, fitted and dispensed by a licensed audiologist or hearing aid specialist.

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

5.6.8 Mental Health

Mental health services, including assessment and treatment in an outpatient treatment program are covered. Moda Behavioral Health can help members locate in-network providers and understand their mental health benefits.

5.6.9 Office Visits (Home, Hospital, Primary Care, Specialist or Urgent Care Visits)

The Plan covers home, urgent care, office and hospital visits for a medical condition, including professional services and supplies that are generally recognized and accepted non-surgical procedures for treating a medical condition. Services and supplies also include those to treat a congenital anomaly. Members can request a second opinion regarding any medical diagnosis or treatment plan from a list of in-network professional providers.

The Plan covers one routine vision exam by an in-network professional provider in each year.

5.6.10 Podiatry Services

Podiatry services are covered for the diagnosis and treatment of a specific current problem. Routine podiatry services are covered for members with a medical condition (e.g., diabetes).

5.6.11 Preventive Healthcare

In accordance with the recommended age limits and frequency guidelines, evidenced-based services rated A or B by the United States Preventive Services Taskforce (USPSTF), immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) of the Center for Disease Control and Prevention, preventive care and screenings recommended by the Health Resources and Services Administration (HRSA) for women, and preventive care and screenings recommended by the Health Resources and Services Administration Bright Futures guidelines for infants, children and adolescents will be covered at no cost to the member when performed by an in-network provider. In the event any of these bodies adopts a new or revised recommendation, the Plan has up to one year before coverage of the related services must be available and effective. Refer to the federal website at www.healthcare.gov/what-are-my-preventive-care-benefits/ or call Customer Service for the list of preventive services covered under the Affordable Care Act.

See Schedule of Benefits for benefit level when services are provided out-of-network. Other preventive services are subject to the applicable cost sharing.

Some frequently used preventive services covered by the Plan are:

a. Colorectal cancer screenings including related facility and anesthesia charges for members age 50 and over or under age 50 who are at high risk for colorectal cancer
b. Newborn hearing screening for hearing loss in newborn infants
c. Periodic health exams for all ages and related routine diagnostic x-ray and lab work are subject to the standard cost sharing
d. Preventive women's healthcare including pelvic and breast exams, Pap tests and mammograms when recommended by a professional provider
e. Routine immunizations for members of all ages
f. Routine prostate rectal exam and Prostate Specific Antigen (PSA) test when recommended by a professional provider
g. Routine vision screening to detect amblyopia, strabismus and defects in visual acuity in children
h. Screening for osteoporosis for women age 60 and up, including bone mineral density tests and other screening exams for osteoporosis

5.6.12 Reconstructive Surgery Following A Mastectomy

The Plan covers reconstructive surgery following a mastectomy for treatment of a medical condition, after consultation with the member and the attending physician.

a. All stages of reconstruction of the breast on which the mastectomy has been performed, including but not limited to nipple reconstruction, skin grafts and stippling of the nipple and areola

b. All stages of surgery and reconstruction of the other breast to produce a symmetrical appearance
c. Prostheses
d. Mastectomy bras
e. Treatment of physical complications of the mastectomy, including lymphedemas
f. Inpatient care related to the mastectomy and post-mastectomy services

This coverage is subject to the same terms and conditions, including the prior authorization and cost sharing provisions otherwise applicable under the Plan.

5.6.13 Spinal Manipulations

The Plan pays for spinal manipulations up to an annual limit. Manipulative treatment includes chiropractic or osteopathic manipulative procedures that treat a neuromusculoskeletal condition. Lab and diagnostic x-rays ordered are subject to the Plan's standard reimbursement rate for lab and diagnostic x-rays.

5.6.14 Surgery

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

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

5.6.15 Therapeutic Injections

Administrative services for therapeutic injections and related supplies, such as allergy shots, are covered when given in a professional provider's office (additional information in section 5.8.2).

Vitamin and mineral injections as well as growth hormones are not covered unless medically necessary for treatment of a specific medical condition.

5.7 OTHER SERVICES

5.7.1 Biofeedback Therapy

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

5.7.2 Breastfeeding Support

Comprehensive lactation support and counseling is covered during pregnancy and/or the postpartum period. The Plan covers the purchase for standard electric breast pumps and equipment. Rental of hospital-grade breast pumps is covered when medically necessary. Purchase

of hospital-grade pumps and charges for supplies such as milk storage bags and extra ice packs, bottles or coolers are not covered.

5.7.3 Home Healthcare

Home healthcare services and supplies, including dialysis services, durable medical equipment benefits, and mental health or chemical dependency treatment, are covered when provided by a home healthcare agency for a member who is homebound and would be covered as an inpatient in a hospital or skilled nursing facility. A home healthcare agency is a licensed public or private agency that specializes in providing skilled nursing and other therapeutic services, such as physical therapy, in a member's home.

This benefit does not include home healthcare, home care services, or supplies provided as part of a hospice treatment plan. These are covered in section 5.7.4.

Home health visits are subject to an annual maximum. Home healthcare requires prior authorization.

5.7.4 Hospice Care

Hospice care includes short-term inpatient care, home care, respite care and related supplies for members who are terminally ill and a written hospice care plan is approved and reviewed at designated intervals by the member's physician. Respite care is continuous care for the member in the most appropriate setting so to relieve persons residing with and caring for the member in hospice from their duties. Durable medical equipment is covered when billed by a licensed hospice care program.

The Plan covers hospice care provided by a licensed hospice care program that uses an interdisciplinary health care team, including but not limited to physicians, registered or licensed practical nurses, physical therapists, occupational or speech therapists, mental health providers, respiratory therapists, home health aides, to provide medically necessary or palliative care. Hospice care plan is generally in a duration of 6 month and may extend to an additional 6 months of care. Hospice care must be prior authorized by Moda Health.

5.7.5 Maternity Care

In utero treatment for the fetus, vaginal or cesarean childbirth delivery in a hospital or birthing center, including facility fees, infertility diagnosis, prenatal and postnatal care and services, including screening, complications of pregnancy (such as fetal distress, gestational diabetes and toxemia) and termination of pregnancy are covered when rendered by a professional provider.

Home births are limited to low risk pregnancy. The Plan does not cover expenses other than medically necessary supplies and fees billed by a professional provider.

Special Right Upon Childbirth. The attending professional provider will determine the care and length of stay, including follow up care, after consultation with the member. Benefits for any hospital length of stay in connection with childbirth for the mother or newborn child will not be restricted to less than 48 hours following a normal vaginal delivery or 96 hours following a cesarean section. Unless the mother's or newborn's attending professional provider, after consulting with

the mother, chooses to discharge the mother or her newborn earlier. Prior authorization is not required for a length of stay up to these limits.

5.7.6 Medical Foods (PKU)

The Plan covers nonprescription formulas and special food products that are part of a diet prescribed and managed by a professional provider for treating Phenylketonuria (PKU).

5.7.7 Supplies, Devices, Appliances and Durable Medical Equipment

Outpatient supplies, braces, splints, prostheses, orthopedic appliances and orthotic devices, supplies or apparatuses used to support, align or correct deformities or to improve the function of moving part, and durable medical equipment, including related sales tax for durable medical equipment and mobility enhancing equipment, are covered. Some examples covered by the Plan are:

Supplies

Include the following:

a. medical supplies used in a professional provider's office
b. application of a cast
c. supplies related to a colostomy or mastectomy
d. insulin pumps and meters for diabetes

Prosthetic and orthotic devices

Prosthetic and orthotic devices, including repair or replacement of such devices, if they are medically necessary to restore or maintain the ability to complete activities of daily living or essential job-related activities. Prosthetic and orthotic devices that are solely for comfort or convenience are not covered.

The first extremity prosthesis after loss of a body part, including artificial eyes and post-mastectomy bras and prosthetic. An additional prosthesis may be authorized if the attending physician provides documentation to Moda Health that a new prosthetic device is medically necessary because of changing fit or poor function.

One conventional intraocular lens or one contact lens or eyeglasses within 90 days following cataract surgery for each eye operated on.

Appliances

Items, including orthopedic braces, used for performing or facilitating the performance of a particular bodily function and foot care appliances for prevention of complication associated with diabetes.

Orthopedic shoes

Orthopedic shoes are covered if they are an integral part of a leg brace or if they are ordered by a professional provider and are medically necessary to restore or maintain the ability to complete activities of daily living or essential job-related activities. If such correction or support is accomplished by modification of a mass-produced shoe, then the covered expense will be limited to

the cost of the modification. The covered expense will not include the original cost of the shoe. Orthopedic shoes or modifications will not be covered if they are solely for comfort or convenience.

Durable medical equipment
Equipment and related supplies that are used primarily to serve a medical purpose, are not generally useful to a member in the absence of a medical condition, are appropriate for use in the member's home and are designed to withstand repeated use. Examples of durable medical equipment include a wheelchair, mobility enhancing equipment, a hospital-type bed, and oxygen. Purchase or maintenance expenses of a wheelchair (including scooters) are subject to a coverage limit (see Schedule of Benefits).

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

Replacement or repair
Replacement or repair of an appliance, prosthetic device, equipment or durable medical equipment, is covered if it was not abused, not used beyond its specifications and not used in a manner to void applicable warranties.

Exclusions
In addition to the exclusions listed in Section 6, the Plan will not cover the following, even if they relate to a condition that is otherwise covered:

a. Those used primarily for comfort, convenience, or cosmetic purposes
b. Wigs and toupees
c. Those used for education or environmental control, such as ramps, hand rails, bath benches, telephones, humidifiers, air filters, air conditioners, heat lamps, tanning lights, whirlpools or hot tubs
d. Therapeutic devices, except for transcutaneous nerve stimulators
e. Incontinence supplies

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

5.7.8 Transplants
The Plan covers medically necessary and appropriate transplant procedures and related services and supplies that conform to accepted medical practice and are not experimental or investigational.

a. Definitions

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

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

Transplant means a procedure or a series of procedures by which:

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

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

b. Covered Benefits. Benefits for transplants are limited as follows:

i. Cost sharing for out-of-network transplant procedures will apply even if the member has met the out-of-network out-of-pocket maximum.
ii. If the recipient or self-donor is enrolled in the Plan, donor costs related to a covered transplant, including expenses resulting from complications and unforeseen effects of the donation, are paid
iii. All transplant services must be prior authorized. Prior authorization requests for transplants will be reviewed to ensure the medical appropriateness and medical necessity of the proposed treatment for the member's medical condition.
iv. Professional provider transplant services are paid according to the benefits for professional providers.
v. Immunosuppressive drugs provided during a hospital stay are paid as a medical supply. Outpatient oral and self-injectable prescription medications for transplant related services are paid under the Pharmacy Prescription Drugs section (see section 5.9).
vi. The Plan does not pay for chemotherapy with autologous or homogenic/allogenic bone marrow transplant for treatment of any type of cancer not approved for coverage.

c. 6-Month Exclusion Period
Transplants are not covered during the first 6 months a person is enrolled in the Plan except if one of the following is met:

i. The exclusion period does not apply if the member has been continuously enrolled in the Plan since birth
ii. The exclusion period does not apply if the member was continuously enrolled in the Plan together with his or her prior plan at least 6 months prior to incurring transplant related expenses. Each day of creditable coverage will reduce the exclusion period by one day

Members have the right to demonstrate the existence of prior creditable coverage by providing Moda Health with a certificate of creditable coverage from a prior plan. A certificate of creditable coverage may be requested from a prior plan or carrier within 24 months of coverage termination. Members who have been enrolled in more than one prior plan should submit all certificates of creditable coverage, as aggregate periods of creditable coverage can be used to reduce the exclusion period.

5.8 MEDICATIONS

5.8.1 Anti-cancer Medication

A prescribed, self-administered anti-cancer medication is covered at the same benefit level as a supply. In addition, anti-cancer medication may require prior authorization by Moda Health or be subject to specific benefit limitations.

5.8.2 Medication Administered by Providers, Infusion Center or Home Infusion

A medication that is given by injection or infusion (intravenous administration) in the professional provider's office, infusion center or home infusion is covered at the same benefit level as a supply. If the pharmaceutical is available in an oral dosage form, the Plan does not cover it in the form of an injectable medication unless it is medically necessary that the member uses the injectable form. In addition, infusion and in-office injectables may require prior authorization or be subject to specific benefit limitations.

5.9 PRESCRIPTION MEDICATION BENEFIT

5.9.1 Pharmacy Deductible (this is only applicable when the drug option includes a separate deductible)

The Plan has an annual deductible for preferred and brand name drugs dispensed at retail, specialty and mail order pharmacies. The amount of the deductible is shown in the Schedule of Benefits. The deductible is calculated separately from any other deductible that may apply to the Plan. For each member, after his or her deductible has been met, covered preferred and brand name drugs will be paid as shown in the Schedule of Benefits.

5.9.2 Definitions

Brand Drugs. A brand drug is sold under a trademark and protected name.

Brand Substitution. Both generic and brand drugs are covered. If a member requests, or the treating professional provider prescribes, a brand drug when a generic equivalent is available, the member will be responsible for the difference in cost between the generic and brand drug, not to exceed the total cost of the drug. In instances when a professional provider restricts brand substitution due to refractory conditions or therapeutic inefficacy, the member will be responsible for the brand copay or coinsurance.

Brand Tier Drugs. Brand drugs, including specialty brand drugs, have been reviewed by Moda Health and do not have significant therapeutic advantage over their preferred alternative(s). These products generally have safe and effective options available under the Select Generic and Preferred tiers.

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

Generic Tier Drugs. Generic drugs have been determined by physicians and pharmacists to be therapeutically equivalent to the brand alternative and often the most cost effective option. Generic drugs must contain the same active ingredients as their brand counterpart and be identical in strength, dosage form and route of administration.

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

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

Preferred Tier Drugs. Preferred drugs, including specialty preferred drugs have been reviewed by ODS Health and found to be clinically effective at a favorable cost when compared to other medications in the same therapeutic class and/or category.

Preferred Drug List. The Moda Health Preferred Drug List is available on myModa. It is intended to provide information pertaining to the coverage of commonly prescribed drugs and is not an all-inclusive list of covered products. New FDA approved drugs are subject to review and may be subject to additional coverage parameters, requirements, or limits established by Moda Health. Drugs that are new to the market are not covered until reviewed by the Moda Health Pharmacy and Therapeutics Committee.

Note: The preferred drug list and the tiering of drugs are subject to change and will be periodically updated. Members with any questions regarding coverage for drugs should contact Customer Service.

Moda Health and the Plan bear no responsibility for any prescribing or dispensing decisions. These decisions are to be made by the professional provider and pharmacist using their professional judgment. Members should consult their professional providers about whether a drug from the preferred list is appropriate for them. This list is not meant to replace a professional provider's judgment when making prescribing decisions.

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

Value Tier Drugs. Value drugs include commonly prescribed products used to treat chronic medical conditions and preserve health. A list of value drugs is available on myModa.

5.9.3 Covered Expenses

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

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

5.9.4 Covered Drug Supply

A covered drug supply includes the following. There is no cost sharing for preventive drugs and immunizations when obtained at in-network retail pharmacies.

a. A legend drug that is medically necessary for the treatment of a medical condition
b. Compounded drugs containing at least one covered drug as the main ingredient
c. Diabetic products and supplies are covered when accompanied by a valid prescription, including insulin, insulin syringes and needles, insulin pens and cartridges, insulin injection aids, blood glucose monitors and test strips, urine test strips, lancets, and glucagon emergency kits and glucose tablet
d. Select legend prenatal vitamins and other prescribed preventive drugs required under the Affordable Care Act
e. Legend contraceptive drugs and devices for birth control and medical conditions covered under the Plan.
f. Immunizations and related administration fees limited to those recommended by the Advisory Committee on Immunization Practices of the Center for Disease Control and Prevention
g. Drugs prescribed as part of a clinical trial but are not the subject of the trial
h. Self-administered anti-cancer medication
i. Medical foods for treating inborn errors of metabolism

5.9.5 Mail Order Pharmacy

Members also have the option of obtaining prescriptions for covered drugs through an exclusive mail order pharmacy. Prescriptions purchased through the mail order drug program are subject to brand substitution. A mail order pharmacy form can be obtained on myModa or by contacting Customer Service.

5.9.6 Specialty Services And Pharmacy

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

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

5.9.7 Prior Authorization

Certain prescription drugs and/or quantities of prescription drugs may require prior authorization. A complete list of drugs that require prior authorization is available on myModa or by contacting Customer Service. Failure to obtain required prior authorization may result in denial of benefits or a penalty (see section 2.1).

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

5.9.8 Step Therapy

Step therapy requires members to try selected drugs before proceeding to alternative treatments. Preferred and brand drugs are available as shown in the Schedule of Benefits once members have tried and failed first line therapies.

5.9.9 Limitations

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

a. New FDA approved drugs are subject to review and may be subject to additional coverage requirements or limits established by the Plan.

b. If a brand drug is dispensed when a generic equivalent is available, the member is responsible for the difference in cost between the generic and brand drug, unless a professional provider restricts brand substitution due to refractory conditions or therapeutic inefficacy.
c. Select specialty drugs that have been determined to have a high discontinuation rate or short durations of use may be limited to a 15-day supply.
d. Claims for drugs purchased outside of the United States and its territories will only be covered in emergency and urgent care situations, except when reasonable accommodation is prior authorized.
e. Early refill of drugs for travel outside of the United States is limited to once every 6 months unless prior authorized.
f. Specialty drugs with dosing intervals beyond 30 days will be assessed an increased copayment consistent with the day supply.

5.9.10 Exclusions

The following services, procedures and conditions are not covered by the Plan. See Section 6 for additional exclusions that may apply.

a. **Cosmetic.** Drugs, including hormones, prescribed or used for cosmetic purposes.
b. **Devices.** Including but not limited to therapeutic devices and appliances. Information for contraceptive devices is in section 5.9.4.
c. **Drug Administration.** A charge for administration or injection of a drug, except for select immunizations at in-network retail pharmacies.
d. **Drugs Covered Under Another Benefit.** Such as drugs covered under home health, medical, etc.
e. **Experimental or Investigational Drugs.** Including any drug used for an experimental or investigational purpose, even if it is otherwise approved by the federal government or recognized as neither experimental nor investigative for other uses or health conditions, except when the drug is recognized as effective for treatment of an indication defined in a reference compendia, or is defined as a safe and efficacious standard of practice in peer-reviewed medical literature, or by the Federal Secretary of Health and Human Services.
f. **Foreign Drug Claims.** Drugs purchased from non-U.S. mail order or online pharmacies or U.S. mail or online pharmacies acting as agents of non-U.S. pharmacies.
g. **Gender Reassignment.** Drugs prescribed (such as hormone supplements) to support gender reassignment.
h. Hair Growth Drugs.
i. Infertility Drugs.
j. **Institutional Drugs.** To be taken by or administered to a member in whole or in part while the member is a patient in a hospital, a sanitarium, a rest home, a skilled nursing facility, an extended care facility, a nursing home, or a similar institution.
k. **Non-Covered Condition.** A drug prescribed for purposes other than to treat a covered medical condition.
l. **Nutritional Supplements and Medical Foods.** Unless determined to be medically necessary**.**

m. **Off-label Usage.** Drugs prescribed for or used for non-FDA approved indications, unless confirmed by other research studies, reference, compendium, or the federal government.
n. **Over the Counter (OTC) Drugs** and prescription drugs for which there is an OTC equivalent or alternative.
o. **Repackaged Drugs.**
p. **Replacement Drugs and/or Supplies.**
q. **Sexual Disorders.** Drugs or devices prescribed or used to treat sexual dysfunction.
r. **Treatment Not Medically Necessary.** Including:
    i. Drugs prescribed for purposes other than treating disease
    ii. Drugs that are either inappropriate or inconsistent with the symptoms or diagnosis of a member's condition
    iii. Drugs that are not representative of the standard treatment by the medical community in the service area in which they are received
    iv. Drugs that are primarily rendered for the convenience of a member or provider
    v. Drugs that are not a cost effective option when considering common alternatives that can be safely provided to a member
s. **Weight Loss Drugs.**

5.9.11 Members' Right to Safe and Effective Pharmacy Services

State and federal laws establish standards to assure safe and effective pharmacy services, and to guarantee members' right to know what drugs are covered under the Plan and what coverage limitations are in the policy. Members who want more information about the drug coverage under the Plan or have a question or a concern about the pharmacy benefit can contact Moda Health at 866-940-0360.

Members who want to know more about their rights under the law or think anything they have received from Moda Health may not conform to the terms of the policy may contact the Washington State Office of Insurance Commissioner at 1-800-562-6900. Members who have a concern about the pharmacists or pharmacies serving them may call the State Department of Health at 360-236-4825.

SECTION 6. GENERAL EXCLUSIONS

In addition to the limitations and exclusions described elsewhere in the Plan, the following services, procedures and conditions are excluded. In addition, any direct complication or consequence that arises from these exclusions will not excluded except for emergency medical conditions. The Plan does not exclude services solely because an injury is sustained as a result of the member being intoxicated or under the influence of a narcotic.

Active Participation in a War or Insurrection
The treatment caused by or arising out of active participation in a war or insurrection.

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

Charges Over the Maximum Plan Allowance
Except when required under the Plan's coordination of benefits rules (see Section 10).

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

Contraception and Reversal Procedures
Surgery to reverse voluntary sterilization procedures (vasectomy or tubal ligation) and any men's contraceptive drug, device or supply that can be legally dispensed without a prescription.

Cosmetic Procedures and Supplies
Any procedure or supply for the purpose of improving or changing appearance without restoring impaired body function, including hormone treatment, rhinoplasty, breast augmentation, lipectomy, liposuction, and hair removal (such as electrolysis and laser). Exceptions are provided for reconstructive surgery following a mastectomy (see section 5.6.12), treatment for congenital anomalies and treatment to restore a physical bodily function lost as a result of a medical condition.

Court-Ordered Services
Those related to unlawful behavior by the member, including a sex offender treatment program and a screening interview or treatment program related to driving under the influence of intoxicants for members age 18 or older. This exclusion does not apply to services provided pursuant to civil commitment proceedings for mental illness.

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

Dental Examinations and Treatment; Orthodontia
Except as specifically provided for in section 5.6.5 or necessary for or resulting from medical treatment if the service is:

a. emergency in nature
b. extraction of teeth to prepare the jaw for radiation treatments of neoplastic disease
c. oral surgery related to trauma and injury

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

Experimental or Investigational Procedures
Including expenses incidental to or incurred as a direct consequence of such procedures.

Faith Healing

Financial Counseling Services

Food Services
"Meals on Wheels" and similar programs.

Gender Identity Disorders
Services and supplies related to gender identity disorders.

Guest Meals in a Hospital or Skilled Nursing Facility

Hearing Aids
Except as specifically provided in section 5.6.7.

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

Homemaker or Housekeeping Services

Homeopathy

Illegal Acts, Riot or Rebellion
Services and supplies for treatment of a medical condition caused by or arising out of a member's voluntary participation in a riot, armed invasion or aggression, insurrection or rebellion or arising directly from an illegal act.

Immunizations
Immunizations for the sole purpose of travel or to prevent illness that may be caused by a work environment.

Infertility
All services and supplies for office visits, diagnosis and treatment of infertility, as well as the cause of infertility.

Inmates
Services and supplies a member receives while in the custody of any state or federal law enforcement authorities or while in jail or prison.

Legal Counseling

Massage Therapy
Therapy that is not treating a medical condition.

Mental Examination and Psychological Testing and Evaluations
For the purpose of adjudication of legal rights, administrative awards or benefits, corrections or social service placement, employment, or any use except as a diagnostic tool for the treatment of mental illness.

Missed Appointments

Naturopathy

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

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

Nuclear Radiation
Any illness or injury 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 nuclear component thereof, unless otherwise required by law.

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

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

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

Orthopedic Shoes
These are not covered, except as provided for in section 5.7.7.

Orthognathic Surgery
Including associated services and supplies, except when required to treat congenital anomalies.

Pastoral and Spiritual Counseling

Physical Examinations
Physical examinations for administrative purposes, such as employment, immigration, school, sports camps, pre-marital exams, travel insurance coverage.

Physical Exercise Programs and Equipment

Private Nursing Services

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

Reports and Records
Including charges for the completion of reports or claim forms.

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

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

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

Services Otherwise Available
Including:

a. those for which payment could be obtained in whole or in part if a member had applied for payment under any city, county, state or federal law, except for Medicaid coverage
b. those for which a member cannot be held liable because of an agreement between the provider rendering the service and another third party payer which has paid or is obligated to pay for such service or supply
c. those for which no charge is made, or for which no charge is normally made in the absence of insurance
d. those a member could have received in a hospital or program operated by a government agency or authority. This exclusion does not apply if the member is a veteran of the armed forces, in which case covered services and supplies furnished by the Veterans' Administration of the United States that are not service-related are eligible for payment according to the terms of the Plan.

Services Provided By a Relative
Relatives, for the purpose of this exclusion, include a spouse or domestic partner, child, sibling, or parent of a member or his or her spouse or domestic partner.

Services Provided By Volunteer Workers

Sexual Disorders
Services or supplies for sexual dysfunction or for sex change procedures and complications resulting from sex change procedures, except for counseling services provided under the mental health benefits.

Support Education
Including:

a. Early intervention services
b. Education-only, court-mandated anger management classes
c. Voluntary mutual support groups, such as Alcoholics Anonymous
d. Family education or support groups, except as required under the Affordable Care Act.

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

Surgery to Alter Refractive Character of the Eye
Any procedure that alters the refractive character of the eye, the purpose of which is to cure or reduce myopia, hyperopia, or astigmatism. Includes reversals or revisions of any procedures that alter the refractive character of the eye and any complications of these procedures.

Taxes
Except for sale tax related to durable medical equipments and mobility enhancing equipments, taxes, including fees and interest.

Telemedical Health Services
Including telephone visits or consultations and telephone psychotherapy.

Telephones and Televisions in a Hospital or Skilled Nursing Facility

Therapies
Services or supplies related to hippotherapy and maintenance therapy and programs, unless in cases where significant deterioration would result in members age 6 and under without such therapy or program.

Third Party Liability Claims
Services and supplies for treatment of a medical condition for which a third party is or may be responsible (see section 9.4.2).

Transportation
Except medically necessary ambulance transport.

Treatment in the Absence of Illness
Including individual or family counseling or treatment for marital, behavioral, financial, family, occupational or religious problems, treatment for "at risk" individuals in the absence of illness, or treatment of "normal" transitional response to stress.

Treatment After Coverage Terminates
Services or supplies that a member receives after coverage ends.

Treatment Not Medically Necessary
Including services or supplies that:

a. Are not medically necessary for the treatment or diagnosis of a condition otherwise covered under the Plan
b. Are inappropriate or inconsistent with the symptoms or diagnosis of a member's condition

c. Are not established as the standard treatment by the medical community in the service area in which they are received
d. Are primarily rendered for the convenience of a member or a provider
e. Are not the least costly of the alternative supplies or levels of service that can be safely provided to a member. For example, coverage is not allowed for an inpatient hospital stay or residential chemical dependency treatment program when an appropriate level of treatment could be delivered in an outpatient setting such as an ambulatory surgery facility or outpatient chemical dependency treatment program

Treatment Prior to Enrollment
Including services and supplies for an admission to a hospital, skilled nursing facility or special facility before the member's coverage under the Plan began. Moda Health provides coverage only for those covered expenses incurred on or after the member's effective date under the Plan.

Vision Care
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.

Vitamins and Minerals
Unless FDA approved and medically necessary for treatment of a specific illness or injury and prescribed and dispensed by a naturopath or other licensed professional provider. This applies whether the vitamin or mineral is oral, injectable, or transdermal.

Wigs, Toupees, Hair Transplants

Work-Related Conditions
Treatment of a medical condition arising out of or in the course of employment or self-employment for wages or profit, whether or not the expense for the service or supply is paid under any workers' compensation provision. This exclusion does not apply to owners, partners or executive officers if they are exempt from workers' compensation laws and their employer does not provide worker's compensation coverage to them.

SECTION 7. ELIGIBILITY

The date a person becomes eligible may be different than the date coverage begins (see section 8.5).

7.1 SUBSCRIBER

A person is eligible to enroll in the Plan if he or she:

a. is a permanent documented full time or part time employee, owner, business partner or corporate officer of a Participating Employer
b. is not a seasonal, substitute, or temporary employee, or an agent, consultant or independent contractor
c. is paid on a regular basis through the payroll system, has federal taxes deducted from such pay, and is reported to Social Security
d. works for the Participating Employer on a regularly scheduled basis at least 20 hours per week
e. has satisfied any eligibility waiting period

Spouses who are both eligible employees may each enroll as a subscriber or one may be covered as an enrolled dependent of the other, but not both.

Subscribers are eligible to remain enrolled if they are on an approved leave of absence under the state or federal medical and family leave laws.

7.2 DEPENDENTS

A subscriber's legal spouse or domestic partner is eligible for coverage. A subscriber's children are eligible until their 26th birthday.

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

a. The natural or adopted child of a subscriber or a subscriber's spouse or domestic partner
b. Children placed for adoption with a subscriber. Adoption paperwork must be provided
c. A newborn child of an enrolled dependent for the first 31 days of the newborn's life
d. Children related to a subscriber by blood or marriage for whom the subscriber is the legal guardian. A court order showing legal guardianship must be provided
e. A child for whom a subscriber or a subscriber's spouse or domestic partner is required to provide coverage by a legal qualified medical child support order (QMCSO)

If a subscriber has a child who has sustained a disability rendering him or her physically or mentally incapable of self-support, that child may be eligible for coverage even though he or she is over 26 years old. To be eligible, the child must be principally dependent on the subscriber for support and have had continuous health coverage. The incapacity must have arisen before the child's 26th birthday. The subscriber must provide Moda Health with a written physician's statement that confirms these conditions existed continuously prior to the child's 26th birthday. Documentation of the child's medical condition must be reviewed and approved by Moda Health's medical consultant. After the child reaches age 28, annual review may also be required on an ongoing basis except in cases where the disability is certified to be permanent.

7.3 QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

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

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

The Plan has detailed procedures for determining whether an order qualifies as a QMCSO. A copy of such procedures is available from the Participating Employer without charge.

7.4 NEW DEPENDENTS

If a subscriber marries or registers a domestic partnership with any state, the spouse or domestic partner and his or her children are eligible to enroll as of the date of the marriage or registration.

When there is no premium change, members are not required by state laws to notify Moda Health to add a child. However, members should submit a completed application to the Group within 60 days of birth, adoption or placement of adoption to ensure the child is enrolled and payment of claims will not be delayed.

When a premium increase is required in order to continue coverage, an application and payment must be submitted within 60 days of birth, adoption or placement for adoption. If payment is required but not received, coverage for the child will end 31 days following birth, adoption or placement. Proof of legal guardianship will be required for coverage of a grandchild beyond the first 31 days from birth.

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

A new dependent may cause a premium increase. Premiums will be adjusted accordingly and will apply to coverage for newborn or adopted children.

7.5 ELIGIBILITY AUDIT

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

SECTION 8. ENROLLMENT

8.1 ENROLLING ELIGIBLE EMPLOYEES

A complete and signed application for the eligible employee and any dependents to be enrolled must be filed within 31 days of becoming eligible to apply for coverage.

The subscriber must notify the Group and Moda Health of any change of address.

8.2 ENROLLING NEW DEPENDENTS

A complete and signed application and, when applicable, a marriage certificate, or adoption or placement for adoption paperwork must be submitted within 31 days for a new spouse or domestic partner and within 60 days for a newborn, newly adopted child or child placed for adoption.

The subscriber must notify Moda Health if family members are added or dropped from coverage, even if it does not affect premiums.

8.3 OPEN ENROLLMENT

Eligible employees and/or any eligible dependents who are not enrolled within the time limits when first becoming eligible must wait for the next open enrollment period to enroll unless:

a. The person qualifies for special enrollment as described in section 8.4
b. A court has ordered that coverage be provided for a spouse or minor child under a subscriber's health benefit plan and request for enrollment is made within 30 days after issuance of the court order
c. The person is employed by an employer who offers multiple health benefit plans and the person elects a different health benefit plan during an open enrollment period
d. The person's coverage under Medicaid, Medicare, Tricare, Indian Health Service or a publicly sponsored or subsidized health plan has been involuntarily terminated within 63 days prior to applying for coverage in a group health benefit plan
e. The Department of Social and Health Services has determined that it is cost-effective to enroll a child who is eligible for medical assistance under chapter 74.09 RCW in the Plan. Request for special enrollment must be made by the department or the subscriber within 60 days of the department's determination

Open enrollment occurs once a year at renewal.

8.4 SPECIAL ENROLLMENT RIGHTS

8.4.1 Loss of Other Coverage

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

a. He or she was covered under a group health plan or had health coverage at the time coverage was previously offered
b. He or she stated in writing at such time that coverage under a group health plan or health coverage was the reason enrollment was declined
c. He or she requests such enrollment not later than 31 days after the previous coverage ended (except for event iv. below, which allows up to 60 days)
d. One of the following events has occurred:
    i. His or her prior coverage was under a COBRA continuation provision and the coverage under such provision was exhausted
    ii. His or her prior coverage was terminated as a result of loss of eligibility for the coverage. Examples of when coverage under a plan may be lost include:
        A. legal separation or divorce
        B. loss of dependent status per plan terms
        C. death
        D. termination of employment
        E. reduction in the number of hours of employment
        F. the plan ceasing to offer coverage to a group of similarly situated persons
        G. moving out of an HMO service area that results in termination of coverage and no other option is available under the plan
        H. termination of the benefit package option, and no substitute option is offered
    iii. Employer contributions toward his or her other coverage were terminated. (If employer contributions cease, the eligible employee or dependent does not have to terminate coverage under the prior plan in order to be eligible for special enrollment.)
    iv. His or her prior coverage was under Medicaid or a children's health insurance program (CHIP) and such coverage was terminated due to loss of eligibility. Special enrollment must be requested within 60 days of the termination

8.4.2 Eligibility for Premium Subsidy

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

The special enrollment rights as described in sections 8.4.1 and 8.4.2 apply:

a. To an eligible employee who loses other coverage or becomes eligible for a premium assistance subsidy
b. To a subscriber's dependent who loses coverage under the other plan or becomes eligible for a premium assistance subsidy
c. To both an eligible employee and his or her dependent if neither is enrolled in the Plan, and either loses coverage under the other plan or becomes eligible for a premium assistance subsidy

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

8.4.3 New Dependents

An eligible employee and spouse or domestic partner will have special enrollment rights if they are not enrolled at the time of the event that caused the eligible employee to gain a new dependent (e.g., marriage, state registration of domestic partnership, birth, adoption, or placement for adoption); however, other existing dependents will not.

8.5 WHEN COVERAGE BEGINS

Coverage for subscribers begins on the enrollment date or after a waiting period, as determined by the Participating Employer and specified in the policy.

Coverage for new dependents through marriage or state registration of domestic partnership begins on the date of marriage or registration.

Coverage for a newborn is effective on the date of the newborn's birth. Coverage for a child newly adopted or placed for adoption is effective on the date of adoption or placement. Court ordered coverage is effective on the first day of the month following the date the Participating Employer determines that an applicable order qualifies as a QMCSO and that the child is eligible for enrollment in the Plan.

Coverage for those enrolling after a determination of eligibility for state subsidy is effective on the day state subsidy becomes eligible. Coverage under special enrollment due to loss of coverage will begin on the day after coverage under the prior plan ends.

The application for coverage must be submitted timely and the necessary premiums must also be paid for coverage to become effective.

Coverage for late enrollees and those enrolling during open enrollment begins on the date the Group specifies with the acceptance of the application. All other plan provisions will apply.

8.6 WHEN COVERAGE ENDS

The circumstances in which a member's coverage will end are described in the following sections. When the subscriber's coverage ends, coverage for all enrolled dependents also ends.

8.6.1 Group Plan Termination

If the Plan is terminated for any reason, coverage ends for the Participating Employers, and members on the date the Plan ends.

8.6.2 Termination of A Participating Employer's Participation in the Plan

If a Participating Employer's participation in the Plan is terminated for any reason, coverage ends for the Participating Employer and its members on the last day of the month through which premiums are paid.

8.6.3 Termination by Subscriber

A subscriber may terminate his or her coverage, or coverage for any enrolled dependent, by giving the Group written notice through the Participating Employer. Coverage will end on the last day of the month through which premiums are paid.

8.6.4 Death

If a subscriber dies, coverage for any enrolled dependents ends on the last day of the month in which the death occurs. Enrolled dependents may extend their coverage (see Section 12). The Group must notify Moda Health of any continuation of coverage, and appropriate premiums must be paid along with the Group's regular monthly payment.

8.6.5 Termination, Layoff or Reduction in Hours of Employment

If employment terminates, coverage ends on the last day of the month in which termination occurs, unless a member chooses to continue coverage (see Section 12).

If a subscriber is laid off and returns to active work within 90 days, he or she and any eligible dependents may enroll in the Plan on the date of rehire and coverage will begin on that date.

If a subscriber experiences a reduction in hours that causes loss of coverage, and within 90 days the hours increase and the subscriber again qualifies for benefits, he or she and any eligible dependents may enroll in the Plan on the date the subscriber qualifies and coverage will begin on that date.

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

The Group must notify Moda Health that a subscriber has been rehired following a layoff or that a subscriber's hours have been increased, and the necessary premiums for coverage must be paid.

8.6.6 Loss of Eligibility by Dependent

An enrolled child will lose eligibility when he or she reaches age 26. Coverage will end on the last day of the month in which the child's eligibility ends, unless the child continues coverage as provided under the Plan (see Section 12).

Coverage ends for an enrolled spouse on the last day of the month in which legal separation occurs a decree of divorce or annulment is entered (regardless of any appeal), unless the divorced spouse continues coverage as provided under the Plan (see Section 12).

Coverage ends for a domestic partner on the last day of the month in which a judgment of dissolution or annulment of the domestic partnership has been entered, unless the former domestic partner continues coverage as provided under the Plan (see Section 12).

8.6.7 Rescission

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

8.6.8 Certificates of Creditable Coverage

Certificates of creditable coverage will be issued when coverage ends, when COBRA coverage ends, and when a member requests a certificate while covered under the Plan or within 2 years of losing coverage.

8.6.9 Continuing Coverage

Additional information is in Continuation of Health Coverage (see Section 12).

SECTION 9. CLAIMS ADMINISTRATION & PAYMENT

9.1 SUBMISSION AND PAYMENT OF CLAIMS

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

9.1.1 Hospital and Professional Provider Claims

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

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

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

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

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

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

9.1.2 Ambulance Claims

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

9.1.3 Prescription Drug Claims

Members who go to an in-network pharmacy should present the Moda Health ID card and pay the prescription cost sharing as required by the Plan. There is no claim to submit.

A member who fills a prescription at an out-of-network pharmacy that does not access Moda Health's claims payment system will need to submit a request for reimbursement by completing the prescription drug claim form available on myModa.

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

9.1.4 Explanation of Benefits (EOB)

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

If a member does not receive an EOB or an email indicating that an EOB is available within a few weeks of the date of service, this may indicate that Moda Health has not received the claim. To be eligible for reimbursement, claims must be received within the claim submission period explained in section 9.1.

9.1.5 Claim Inquiries

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

9.1.6 Plan Time Frames for Processing Claims

For claims that do not require additional information, Moda Health will pay or deny the claim, and an EOB will be sent to the member within 30 days after receiving the claim. For claims denied due to the experimental or investigational exclusion, a written notice will be sent within 20 business days of receipt of a fully documented request. Moda Health may extend the review time upon written consent from the member.

For other claims, if additional time is needed to process the claim for reasons beyond Moda Health's control, a notice of delay will be sent to the member explaining those reasons within 30 days after Moda Health receives the claim. Moda Health will then complete its processing and send an EOB to the member no more than 45 days after receiving the claim. If additional information is needed to complete processing of the claim, the notice of delay will describe the information needed and the party responsible for providing the additional information will have 45 days to submit it. Once the additional information is received, processing of the claim will be completed within 15 days. Submission of information necessary to process a claim is subject to the Plan's claim submission period explained in section 9.1.

9.2 GRIEVANCE AND APPEALS

9.2.1 Definitions

For purposes of section 9.2, the following definitions apply:

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

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

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

Grievance means a written complaint submitted by or on behalf of a member regarding issues other than denial of payment for healthcare services. Grievance includes dissatisfaction with healthcare services, delays in obtaining healthcare services, conflicts with providers or Moda Health's staff, and dissatisfaction with Moda Health's practices or actions unrelated to healthcare services.

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

Pre-service claim means any claim for a benefit under the Plan for care or services that require prior authorization.

Utilization Review means a system of reviewing the medical necessity, appropriateness, or quality of medical care services and supplies using specified guidelines, including preadmission certification, the application of practice guidelines, continued stay review, discharge planning, prior authorization of ambulatory procedures, and retrospective review. An adverse benefit determination that the item or service is not medically necessary or appropriate, is

investigational or experimental, or in which the decision as to whether a benefit is covered involved a medical judgment is a utilization review decision.

9.2.2 Grievance

Members and applicants may submit a grievance to Moda Health or contact Customer Service for assistance. Moda Health will make a determination and notify the person submitting the grievance of the determination.

9.2.3 Time Limit for Submitting Appeals

A member has **180 days** from the date of an adverse benefit determination to submit an initial written appeal. If an appeal is not submitted within the timeframes outlined in this section, the rights to the appeals process will be lost. In addition, the right to file suit in court may be lost, as the member will have failed to exhaust his or her internal appeal rights, which is generally a prerequisite to bringing suit.

9.2.4 The Review Process

The Plan has a 2-level internal review process consisting of a first level appeal and a second level appeal. If a member is not satisfied with the outcome of the second level appeal, the member may request external review by an independent review organization. The first and second levels of appeal will need to be exhausted to proceed to external review, unless Moda Health agrees otherwise or in accordance to section 9.2.8. These 2 levels of review must also be exhausted before a member can exercise the right to file a lawsuit in court under ERISA section 502(a) unless Moda Health fails to meet the internal timelines for review or to provide all of the information and notices required under federal law.

9.2.5 First Level Appeals

Before filing an appeal, it may be possible to resolve an appeal with a phone call to Customer Service. Otherwise, an appeal may be submitted verbally or in writing to Moda Health. If necessary, Customer Service can provide assistance filing an appeal or explain the full appeal process. The member may review the claim file and present evidence and testimony as part of the appeal process, and may appoint a representative to act on his or her behalf. Moda Health will conduct an investigation by persons who were not involved in the initial determination. Upon request and free of charge, the member may have reasonable access to copies of documents, records, and other information relevant to the claim.

Appeals related to an urgent care claim will be entitled to expedited review upon request. Expedited reviews will be completed within 72 hours in total for the first and second level appeals combined after receipt of those appeals by Moda Health, not counting the lapse between the first level appeal determination and receipt of the second level appeal by Moda Health. If the member fails to provide sufficient information for Moda Health to make a decision at each appeal level, Moda Health will notify the member within 24 hours of receipt of the appeal of the specific information necessary to make a decision. The member must provide the specified information as soon as possible.

Investigation of an appeal will be completed and a notice sent within 14 days and no more than 20 business days for post-service denials due to experimental or investigational basis. Investigation of other post-service appeals may be extended with a notice. Investigation will be completed and a written notice sent within 30 days, including the basis for the decision, and if applicable, information on the right to a second level appeal.

9.2.6 Second Level Appeals

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

Investigations and responses to a second level appeal will be by persons who were not involved in the initial determinations, and will follow the same timelines as those for a first level appeal. The member may review the claim file and present evidence and testimony as part of the appeal process, and may appoint a representative to act on his or her behalf. If new or additional evidence or rationale is used by Moda Health in connection with the claim, it will be provided to the member, in advance and free of charge, before any final internal adverse benefit determination. Members may respond to this information before Moda Health's determination is finalized. Moda Health will notify the member in writing of the decision, the basis for the decision, and if applicable, information on the right to file a lawsuit under ERISA Section 502(a) and the right to request an external review.

9.2.7 Expedited Review and Concurrent Expedited Review

Members can request expedited internal or external review or concurrent expedited review for the following reasons:

a. They are currently receiving or are prescribed treatment for a medical condition and a treating professional provider believes that a delay in treatment based on the standard review time may seriously jeopardize their lives, overall health or ability to regain maximum function, or would subject them to severe and intolerable pain; or
b. The adverse benefit determination is related to admission, availability of care, continued stay or health care services received on an emergency basis where they have not been discharged.

Expedited review may be submitted orally by the member or an authorized representative or provider. Moda Health will expedite the review and respond verbally within 24 hours when possible but in no case longer than 72 hours of the receipt of the request. A written response will also be sent no later than 72 hours after the decision is made. If additional information is needed, Moda Health will notify the member or authorized representative following the process for urgent care claims.

Members may not request expedited review if the treatment has already been delivered and the review only involves payment for the delivered treatment; if the situation is not urgent; or if the situation does not involve the delivery of services for an existing medical condition.

9.2.8 External Review

If the claim meets the criteria below, a member may request that the claim be reviewed by an independent review organization (IRO).

a. The dispute must relate to an adverse benefit determination based on a utilization review decision; or cases in which Moda Health fails to meet the internal timeline for review or the federal requirements for providing related information and notices.
b. The request for external review must be in writing no more than 180 days after receipt of the final internal adverse benefit determination. For an urgent care claim or when the claim concerns a condition for which the member received emergency services and is still hospitalized, a request for external review may be expedited or simultaneous with a request for internal appeal review.
c. Moda Health will provide the information to the independent review organization within 3 business days and notify the member the name of the independent review organization and the right to submit additional information within one day of selecting the independent review organization.
d. The member must have exhausted the appeal process described in sections 9.2.5 and 9.2.6. However, Moda Health may waive this requirement and have a dispute referred directly to external review with the member's consent.
e. The member shall provide complete and accurate information to the independent review organization within 5 business days from receipt of the notice.
f. The independent review organization will make a final determination and notify the member within 15 calendar days for non-expedited reviews (within 20 calendar days with incomplete information and within 25 calendar days for exceptional circumstances together with incomplete information) or 72 hours for expedited review.

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

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

9.2.9 Additional Member Rights

Members have the right to file a complaint or seek assistance from the Office of the Insurance Commissioner. Assistance is available:

By phone: 800-562-6900
By internet: http://www.insurance.wa.gov/consumers/health/appeal/Table-of-Contents.shtml

By mail: Office of the Washington State Insurance Commissioner
Consumer Protection Division
P.O. Box 40256
Olympia, WA 98504-0256

This information is subject to change upon notice from the Office of the Insurance Commissioner.

9.3 CONTINUITY OF CARE

9.3.1 Continuity of Care

Moda Health will provide continuity of care for a limited period of time if a medical services contract or other contract for a primary care provider's services is terminated by Moda Health without cause.

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

a. The member must request continuity of care from Moda Health
b. The contractual relationship between the primary care provider and Moda Health, with respect to the Plan covering the member, has ended by Moda Health without cause

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

a. The contractual relationship between a primary care provider and Moda Health has ended because he or she:

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

b. The contractual relationship has terminated in accordance with provisions of the medical services contract relating to quality of care and all contractual appeal rights of the professional provider have been exhausted.

Moda Health will not provide continuity of care if the member leaves the Plan or if the Group discontinues the Plan in which the member is enrolled.

9.3.2 Length of Continuity of Care

Continuity of care will end 60 days after notice of termination is sent to the members.

9.3.3 Notice Requirement

Moda Health shall make a good faith effort to provide written notice of a termination to all members who are patients seen on a regular basis by the primary care provider whose contract is terminating, regardless if the termination was for cause or without cause.

9.4 BENEFITS AVAILABLE FROM OTHER SOURCES

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

9.4.1 Coordination of Benefits (COB)

This provision applies to the Plan when a member has healthcare coverage under more than one plan. A complete explanation of COB is in Section 10.

9.4.2 Third-Party Liability

A member may have a legal right to recover benefit or healthcare costs from a third party as a result of a medical condition for which benefits or healthcare costs were paid by Moda Health. For example, a member who is injured may be able to recover the benefits or healthcare costs from a person or entity responsible for the injury or from an insurer, including different forms of liability insurance, or uninsured motorist coverage or under-insured motorist coverage. As another example, a member may become sick or be injured in the course of employment, in which case the employer or a workers' compensation insurer may be responsible for healthcare expenses connected with the medical condition. If Moda Health makes an advance payment of benefits, as described below, it is entitled to be reimbursed for benefits it paid that are associated with any medical condition that are or may be recoverable from a third party or other source. Moda Health will only seek to recover amounts a member has received from third parties to the extent those amounts exceed full compensation to the member for the injuries, losses or damages. Amounts received by Moda Health through these recoveries help reduce the cost of premiums and providing benefits.

Payment of benefits where a third party may be legally liable is excluded under the terms of the Plan. Because recovery from a third party may be difficult and take a long time, as a service to the member, Moda Health will pay a member's expenses based on the understanding and agreement that the member is required to honor Moda Health's subrogation rights as discussed below, and, if requested, to reimburse Moda Health from any recovery the member may receive in excess of full compensation for the loss, no matter how the recovery is characterized.

Upon claiming or accepting benefits, or the provision of benefits, under the terms of the Plan, the member agrees that Moda Health has the remedies and rights described in section 9.4.2. Moda Health may elect to seek recovery under one or more of the procedures outlined in this section. The member agrees to do whatever is necessary to fully secure and protect, and to do nothing to prejudice, Moda Health's right of reimbursement or subrogation as discussed in this section.

10.4.2.1 Definitions

For purposes of section 9.4.2, the following definitions apply:

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

Recovery Funds means any amount recovered from a third party.

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

Third Party Claim means any claim, lawsuit, settlement, award, verdict, judgment, arbitration decision or other action against a third party (or any right to assert the foregoing) by or on behalf of a member, regardless of how the claims or damages or recovery funds are characterized. (For example, a member who has received payment of medical expenses from Moda Health may file a third party claim against the party responsible for the member's injuries, but only seek the recovery of non-economic damages. In that case, Moda Health is still entitled to recover benefits as described in section 9.4.2.)

10.4.2.2 Subrogation

Upon payment by the Plan, Moda Health shall be subrogated to all of the member's rights of recoveries therefore, and the member shall do whatever is necessary to secure such rights and do nothing to prejudice them. Moda Health may pursue the third party in its own name, or in the name of the member. Moda Health is entitled to all subrogation rights and remedies under the common and statutory law, as well as under the Plan, to the extent the remedies exceed full compensation to the member for the loss.

10.4.2.3 Right of Recovery

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

a. The member holds any rights of recovery against the third party in trust for Moda Health, but only for the amount of benefits Moda Health paid for that medical condition in excess of full compensation for the loss.

b. Moda Health is entitled to receive the amount of benefits it has paid for that medical condition out of any settlement or judgment which results from exercising the right of recovery against the third party. This is so regardless of whether the third party admits liability or asserts that the member is also at fault. In addition, Moda Health is entitled to receive the amount of benefits it has paid whether the healthcare expenses are itemized or expressly excluded in the third party recovery.

c. The member may incur attorney's fees and costs in connection with obtaining recovery, and the member may subtract from the money to be paid back to Moda Health, as an expense for collecting from the other party, a proportionate share of reasonable attorney fees.

d. Moda Health may ask the member to sign an agreement to abide by the terms of this section. Moda Health will not be required to pay benefits for the medical condition until the agreement is properly signed and returned.

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

10.4.2.4 Motor Vehicle Accidents

Any expense for injury or illness that results from a motor vehicle accident, and is payable under a motor vehicle insurance policy is not a covered benefit under the Plan and will not be paid by Moda Health.

If a claim for healthcare expenses arising out of a motor vehicle accident is filed with Moda Health, and motor vehicle insurance has not yet paid, then Moda Health may advance benefits, subject to sections 10.4.2.2 and 10.4.2.3.

10.4.2.5 Additional Third Party Liability Provisions

In connection with Moda Health's rights as discussed in the above sections, members shall do one or more of the following, and agree that Moda Health may do one or more of the following:

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

b. Upon request from Moda Health, the member shall provide all information available to the member, or any representative or attorney representing the member, relating to the potential third party claim. The member and his or her representatives are obligated to notify Moda Health in advance of any claim (written or oral) and/or any lawsuit made against a third party seeking recovery of any damages from the third party, whether or not the member is seeking recovery of benefits paid by Moda Health from the third party.

c. A member seeking advance payment of benefits by Moda Health in accordance with section 9.4.2 must fill out, sign and return to Moda Health a Third-Party Questionnaire and Agreement. If the member is a minor or legally incapable of contracting, the member's parent or guardian must sign, and if the member has retained an attorney, then the attorney must also sign agreement.

d. The member shall cooperate with Moda Health to protect its recovery rights, and in addition, but not by way of limitation, shall:

    i. Sign and deliver such documents Moda Health reasonably requires to protect its rights
    ii. Provide any information to Moda Health relevant to the application of the provisions of section 9.4.2, including medical information (doctors' reports, chart notes, diagnostic test results, etc.), settlement correspondence, copies of pleadings or demands, and settlement agreements, releases or judgments
    iii. Take such actions as Moda Health may reasonably request to assist Moda Health in enforcing its third party recovery rights

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

f. The member agrees that Moda Health may notify any third party, or third party's representatives or insurers, of its recovery rights set forth in section 9.4.2.

g. Even without the member's written authorization, Moda Health may release to, or obtain from, any other insurer, organization or person, any information it needs to carry out the provisions of section 9.4.2.

h. Section 10.4.2 applies to any member for whom advance payment of benefits is made by Moda Health whether or not the event giving rise to the member's injuries occurred before the member became covered by Moda Health.

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

j. If the member or the member's representatives fail to do any of the foregoing acts at Moda Health's request, then Moda Health may recover any benefits it has advanced for any injury or illness through legal action against the member or the member's representative.

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

l. If any term, provision, agreement or condition of section 9.4.2 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.

9.5 MEDICARE

To the extent permitted by law, the Plan will not pay benefits toward any part of a covered expense to the extent the covered expense is covered by Medicare.

SECTION 10. COORDINATION OF BENEFITS

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

10.1 DEFINITIONS

For purposes of Section 10, the following definitions apply:

Plan means a form of coverage with which coordination is allowed. Separate parts of a plan for members of a group that are provided through alternative contracts that are intended to be part of a coordinated package of benefits are considered one plan and there is no coordination of benefits among the separate parts of the plan.

Plan includes:

a. Group, individual or blanket disability insurance contracts and group or individual contracts marketed by issuers
b. Closed panel plans or other forms of group or individual coverage
c. The medical care components of long-term care contracts, such as skilled nursing care
d. Medicare or other government programs, other than Medicaid, and any other coverage required or provided by law

Plan does not include:

a. Hospital indemnity or fixed payment coverage benefits or other fixed indemnity or payment coverage
b. Accident-only coverage
c. Specified disease or specified accident coverage
d. Limited benefit health coverage
e. School accident and similar coverages that cover students for accidents only
f. Benefits for non-medical components of group long-term care policies
g. Medicare supplement policies
h. A state plan under Medicaid
i. A governmental plans, which by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plans
j. Automobile insurance policies required by statute to provide medical benefits
k. Benefits provided as part of a direct agreement with a direct patient-provider primary care practice

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

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

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

An **Allowable Expense** means a healthcare expense, including deductibles, copayments or coinsurance, that is covered at least in part by any plan covering the member. When a plan provides benefits in the form of a service rather than cash payments, the reasonable cash value of the service will also be considered an allowable expense and a benefit paid. When Medicare is primary, Medicare's allowable amount is the allowable expense.

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

a. An expense that is not covered by any plan covering the member is not an allowable expense
b. The difference between the cost of a semi-private hospital room and a private hospital room, unless one of the plans provides coverage for private hospital room expenses
c. If a member is covered by two or more plans that compute their benefit payment on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an allowable expense
d. If a member is covered by two or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of, the negotiated fees is not an allowable expense

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

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

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

10.2 HOW COB WORKS

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

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

The **secondary plan** (the plan(s) that pay(s) benefits after the primary plan) will reduce the benefits it pays so that payments from all plans cannot be less than the same allowable expense as the secondary plan would have paid if it was the primary. In addition, the secondary plan will calculate its savings (its amount paid subtracted from the amount it would have paid had it been the primary plan) and record these savings as a benefit reserve for the member. This reserve will be used to pay any allowable expenses not otherwise paid, that are incurred during the calendar year.

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

For coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits, this supplementary coverage is excess to any other parts of the plan provided by that group. Otherwise, any other plan that does not contain a coordination of benefits provision that is consistent with chapter 284-51 of the Washington Administrative Code is always primary unless the provisions of both plans state that the complying plan is primary.

10.3 ORDER OF BENEFIT DETERMINATION (WHICH PLAN PAYS FIRST?)

The first of the following rules that applies will govern:

a. **Non-dependent/Dependent.** If a plan covers the member as other than a dependent, for example, an employee, member of an organization, subscriber, or retiree, then that plan will determine its benefits before a plan which covers the member as a dependent. However, if the member is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the member as a dependent and primary to the plan covering the member as other than a dependent (e.g. a retired employee), then the order of benefits between the two plans is reversed so that the plan covering the member as an employee, member of an organization, subscriber, or retiree is the secondary plan and the other plan covering the member as a dependent is the primary plan.

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

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

   i. If a court decree states that one of the parents is responsible for the healthcare expenses of the child, and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no healthcare coverage for the dependent child's healthcare expenses but that parent's spouse does, the plan under the parent's spouse is primary. This rule applies to plan years commencing after the plan is given notice of the court decree.

   ii. If a court decree states that one parent is to assume primary financial responsibility for the dependent child but does not mention responsibility for healthcare expenses, the plan of the parent assuming financial responsibility is primary.

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

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

      A. The plan covering the custodial parent
      B. The plan covering the spouse of the custodial parent
      C. The plan covering the non-custodial parent
      D. The plan covering the spouse of the non-custodial parent

   This rule does not apply if the Non-dependent/Dependent rule can determine the order of benefits.

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

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

f. **COBRA or State Continuation Coverage.** If a member whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the member as an employee, member of an organization, subscriber, or retiree or as a dependent of the same, is the primary plan and the COBRA or other continuation coverage is the secondary plan. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of the benefits, this rule is ignored. This rule does not apply if the Non-dependent/Dependent rule can determine the order of benefits.

g. **Longer/Shorter Length of Coverage.** The plan that covered a member as an employee, member of an organization, subscriber, or retiree (non-dependent) longer is the primary plan and the plan that covered the member for the shorter period of time is the secondary plan. This rule does not apply if the Non-dependent/Dependent rule can determine the order of benefits.

h. **None of the Above.** If the preceding rules do not determine the order of benefits within 30 calendar days after the plans have received the information needed to pay the claim, the allowable expenses shall be shared equally between the plans. In addition, this Plan will not pay more than it would have paid had it been the primary plan.

Where part of a plan coordinates benefits and a part does not, each part will be treated as a separate plan.

Claims involving coordination of benefits will be paid by the primary plan within 60 calendar days of receipt or of determining it is the primary plan. If the primary plan fails to pay within 60 calendar days, the provider may submit the claim to the secondary plan which will pay the claim as primary within 30 calendar days.

10.4 EFFECT ON THE BENEFITS OF THIS PLAN

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

10.5 RIGHT TO COLLECT AND RELEASE NEEDED INFORMATION

Certain facts about healthcare coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. Moda Health may get the facts it needs from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other plans covering the member. Moda Health

need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give Moda Health any facts it needs to apply those rules and determine benefits payable.

10.6 FACILITY OF PAYMENT

If payments that should have been made under this Plan are made by another plan, Moda Health have the right, at its discretion, to remit to the other plan the amount it determines appropriate to satisfy the intent of this provision. The amounts paid to the other plan are considered benefits paid under this Plan. To the extent of such payments, Moda Health is fully discharged from liability under this Plan.

10.7 RIGHT OF RECOVERY

Moda Health has the right to recover excess payment whenever it has paid allowable expenses in excess of the maximum amount of payment necessary to satisfy the intent of this provision. Moda Health may recover the excess payment from any other person or other health carrier or plan that has received payment.

10.8 QUESTIONS ABOUT COORDINATION OF BENEFITS

Members should contact the Washington State Office of the Insurance Commissioner if they have questions about coordination of benefits.

10.9 NOTICE TO MEMBERS

If a member is covered by more than one health benefit plan and is not sure which is the primary plan, either the member or the provider should contact one of the plans to verify. The plan contacted is responsible to working with the other plan to determine the order of coordination and then inform the member within 30 days.

CAUTION: All health plans have timely claim filing requirements. If a member or the provider fails to submit a claim to the secondary plan within that plan's claim filing time limit, the claim may be denied. If the primary plan delays its claim processing, the member or provider should submit the claim to the secondary plan within its claim filing time limit to prevent a denial of the claim.

To avoid delays in claim processing, members who are covered by more than one plan should promptly report to their providers and plans any changes in their coverage.

SECTION 11. MISCELLANEOUS PROVISIONS

11.1 REQUEST FOR INFORMATION

When necessary to process claims, Moda Health may require a member to submit information concerning benefits to which the member is entitled. Moda Health may also require a member to authorize any provider to give Moda Health information about a condition for which the member claims benefits.

11.2 CONFIDENTIALITY OF MEMBER INFORMATION

Keeping a member's protected health information confidential is very important to Moda Health. Protected health information includes enrollment, claims, and medical and dental information. Moda Health uses such information internally for claims payment, referrals and authorization of services, and business operations such as case management and quality management programs. Moda Health does not sell this information. The Notice of Privacy Practices provides more complete detail about how Moda Health uses members' information. A copy of the notice is available on the Moda website by following the HIPAA link or by calling Moda Health at 877-605-3229, extension 4492.

11.3 TRANSFER OF BENEFITS

Only members are entitled to benefits under the Plan. These benefits are not assignable or transferable to anyone else. Any attempted assignment or transfer will not be binding on Moda Health except that Moda Health shall pay amounts due under the Plan directly to a provider upon a member's written requests.

11.4 RECOVERY OF BENEFITS PAID BY MISTAKE

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

11.5 CONTRACT PROVISIONS

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

11.6 REPLACING ANOTHER PLAN

If the Plan replaces an earlier Moda Health or other group plan, in either case, the Plan shall give credit for the satisfaction or partial satisfaction for any deductibles actually paid under the prior plan for the same or overlapping benefit periods with the Plan, but the credit shall apply or be given only to the extent that the expenses are recognized under the terms of the Plan and are subject to a similar deductible provision.

11.7 RESPONSIBILITY FOR QUALITY OF MEDICAL CARE

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

11.8 WARRANTIES

All statements made by the Group or a member, unless fraudulent, will be considered as representations and not warranties. No statement made for the purpose of effecting 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 to the member or member's beneficiary.

11.9 NO WAIVER

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

11.10 GROUP IS THE AGENT

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

11.11 GOVERNING LAW

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

11.12 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 Washington.

11.13 TIME LIMITS FOR FILING A LAWSUIT

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

11.14 EVALUATION OF NEW TECHNOLOGY

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

SECTION 12. CONTINUATION OF HEALTH COVERAGE

The following sections on continuation of coverage may apply. Members should check with the Participating Employer's benefits manager to find out whether they qualify for this coverage. Both subscribers and their dependents should read the following sections carefully.

12.1 3-MONTH CONTINUATION COVERAGE UNDER STATE LAW

Members have the right to 3 months of continuation coverage after group coverage ends. This provision applies when the Group is not required by federal law to offer COBRA or when members are not eligible for COBRA.

A member whose COBRA coverage ends less than 3 months after it began can continue coverage under this section for the balance of the 3-month period. Members whose COBRA coverage is in force for at least 3 months are not eligible for this continuation coverage when COBRA coverage ends.

To continue coverage under this provision, the member must make timely premium payments to the Group for remittance to Moda Health. At the end of the 3-month period, the member may apply for and enroll in a conversion plan.

All coverage under this provision ends automatically on the date the policy is terminated.

12.2 COBRA CONTINUATION COVERAGE

12.2.1 Introduction

The Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") is a federal law requiring certain employer-sponsored group health plans to offer qualified beneficiaries the opportunity to elect a temporary extension of health coverage if coverage is lost due to a qualifying event. For purposes of section 12.2, a qualified beneficiary is someone who is covered under the Plan the day before a qualifying event, and can include the subscriber and the subscriber's spouse and dependent children. The COBRA Administrator means either the Group or a third party administrator delegated by the Group to handle COBRA administration. Specific qualifying events are listed below.

COBRA only applies to employers with 20 or more employees on 50% of the typical business days in the prior calendar year. Moda Health will provide COBRA continuation coverage to those qualified beneficiaries who elect coverage under COBRA, subject to the following conditions:

a. Moda Health will offer no greater COBRA rights than the COBRA statute requires

b. Moda Health will not provide COBRA coverage for those qualified beneficiaries who do not comply with the requirements outlined below
c. Moda Health will not provide COBRA coverage if the COBRA Administrator fails to provide the required COBRA notices within the statutory time periods or if the COBRA Administrator otherwise fails to comply with any of the requirements outlined below
d. Moda Health will not provide a disability extension if the COBRA Administrator fails to notify Moda Health within 60 days of its receipt of a disability extension notice from a qualified beneficiary

12.2.2 Qualifying Events

Subscriber. A subscriber may elect continuation coverage if coverage is lost because of termination of employment (other than termination for gross misconduct, which may include misrepresenting immigration status to obtain employment), or a reduction in hours.

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

a. The death of the subscriber
b. The termination of the subscriber's employment (for reasons other than gross misconduct) or reduction in the subscriber's hours of employment with the Participating Employer
c. Divorce or legal separation from the subscriber
d. The subscriber becomes entitled to Medicare

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

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

a. The death of the subscriber
b. The termination of the subscriber's employment (for reasons other than gross misconduct) or reduction in a subscriber's hours of employment with the Participating Employer
c. Parents' divorce or legal separation
d. The subscriber becomes entitled to Medicare
e. The child ceases to be a "child " under the Plan

Domestic Partners. A subscriber who at the time of the qualifying event was covering his or her domestic partner under the Plan, can elect COBRA continuation coverage that includes continuing coverage for the domestic partner. A domestic partner who is covered under the Plan by the subscriber is not a "qualified beneficiary" and, therefore, does not have an independent election right under COBRA. This also means that the domestic partner's coverage ceases immediately when

the subscriber's COBRA coverage terminates (for example, due to the subscriber's death or because the subscriber becomes covered under another plan).

Retirees. If the Plan provides retiree coverage and the subscriber's former employer files a chapter 11 bankruptcy proceeding, this may be a qualifying event for the retiree who loses coverage as a result, and for his or her covered dependents.

12.2.3 Other Coverage

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

12.2.4 Notice and Election Requirements

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

Election Notice. Members will be notified of their right to continuation coverage within 14 days after the COBRA Administrator receives a timely qualifying event notice.

Otherwise, members will be notified by the COBRA Administrator of the right to elect COBRA continuation coverage within 44 days of any of the following events that result in a loss of coverage: the subscriber's termination of employment (other than for gross misconduct), reduction in hours, death of the subscriber, the subscriber's becoming entitled to Medicare, or the Group files for Chapter 11 reorganization.

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

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

12.2.5 COBRA Premiums

Those eligible for continuation coverage do not have to show that they are insurable. However, they are responsible for all premiums for continuation coverage. The first payment for continuation coverage is due within 45 days after a qualified beneficiary provides notice of electing coverage (this is the date the election notice is postmarked, if mailed, or the date the election notice is received by the COBRA Administrator, if hand-delivered). This payment must include the amount necessary to cover all months that have elapsed between the date regular coverage ended and the

payment date. Subsequent payments are due on the first day of the month; however, there will be a grace period of 30 days to pay the premiums. Moda Health will not send a bill for any payments due. The qualified beneficiary is responsible for paying the applicable premiums, in good funds, when due; otherwise continuation coverage will end and may not be reinstated. The premium rate may include a 2% add-on to cover administrative expenses.

12.2.6 Length of Continuation Coverage

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

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

36-Month Continuation Period. In the case of losses of coverage due to a subscriber's death, divorce or legal separation, or a child ceasing to be a dependent under the terms of the Plan, coverage under the Plan may be continued for up to a total of 36 months.

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

Extended Period. In the case of loss of coverage due to the bankruptcy of the Group, coverage for the retired subscriber may be continued up to his or her death; coverage for each dependent may be continued up to the dependent's death or 36 months after the retired subscriber's death, whichever is earlier.

12.2.7 Extending the Length of COBRA Coverage

If COBRA is elected, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. The COBRA Administrator must be notified of a disability or a second qualifying event in order to extend the period of COBRA coverage. If the qualified beneficiary fails to provide notice of a disability or second qualifying event, he or she will lose the right to extend the period of COBRA coverage.

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

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

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

A qualified beneficiary must provide the COBRA Administrator a copy of the Social Security Administration's determination within the 18-month period following the subscriber's termination of employment or reduction of hours, and not later than 60 days after the Social Security Administration's determination was made. If the notice is not provided within this timeframe, then there will be no disability extension of COBRA coverage. The premiums for COBRA coverage may increase after the 18th month of coverage to 150% of the premiums.

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

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

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

12.2.8 Newborn or Adopted Child

If, during continuation coverage, a child is born to or placed for adoption with the subscriber, the child is considered a qualified beneficiary. The subscriber may elect continuation coverage for the child provided the child satisfies the otherwise applicable plan eligibility requirements (for example, age). The subscriber or a family member must notify the COBRA Administrator within 60 days of the birth or placement to obtain continuation coverage. If the subscriber or family member fails to notify the COBRA Administrator in a timely fashion, the child will not be eligible for continuation coverage.

12.2.9 Special Enrollment and Open Enrollment

Qualified beneficiaries under continuation coverage have the same rights as similarly-situated members who are not enrolled in COBRA. A qualified beneficiary may add newborns, new spouses, or domestic partners, and adopted children (or children placed for adoption) as covered dependents in accordance with the Plan's eligibility and enrollment rules, including HIPAA special enrollment. If non-COBRA members can change plans at open enrollment, COBRA members may also change plans at open enrollment.

12.2.10 When Continuation Coverage Ends

COBRA coverage will automatically terminate before the end of the maximum period if:

a. any required premiums are not paid in full on time
b. a qualified beneficiary becomes covered under another group health plan
c. a qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing COBRA. (However, if the qualifying event is the Group's or Participating Employer's bankruptcy, the qualified beneficiary will not lose COBRA because of entitlement to Medicare benefits)
d. the Group or Participating Employer ceases to provide any group health plan for its employees
e. during a disability extension period (see section 12.2.7), the disabled qualified beneficiary is determined by the Social Security Administration to be no longer disabled (COBRA coverage for all qualified beneficiaries, not just the disabled qualified beneficiary, will end).

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

When COBRA continuation coverage ends, members *may* be eligible to enroll in an individual conversion plan provided by Moda Health.

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

12.3 MODA INDIVIDUAL PLAN

In addition to the continuation coverage mentioned in section 12.1 and 12.2, members may enroll in an individual plan offered by Moda Health. Moda Health must receive an application within 60 days of the loss of coverage.

12.4 UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

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

If a subscriber does not elect continuation coverage under USERRA or if continuation coverage is terminated or exhausted, coverage will be reinstated on the first day he or she returns to active employment with the Participating Employer if released under honorable conditions, but only if he or she returns to active employment:

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

Regardless of the length of the leave, a reasonable amount of travel time or recovery time for an illness or injury determined by the Veteran's Administration (VA) to be service connected will be allowed.

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

12.5 FAMILY AND MEDICAL LEAVE

Subscribers should check with the Group to find out if they qualify for this coverage.

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

a. Affected member(s) will remain eligible for coverage during a family and medical leave.
b. If members elect not to remain enrolled during a family and medical leave, they will be eligible to re-enroll in the Plan on the date the subscriber returns from leave. To re-enroll, a complete and signed application must be submitted within 60 days of the return to work. All of the terms and conditions of the Plan will resume at the time of re-enrollment as if there

had been no lapse in coverage. Any exclusion period served prior to the leave will be credited and any group eligibility waiting period under the Plan will not have to be re-served. However, no exclusion period credits will be received for the period of the leave.

c. A subscriber's rights under family and medical leave will be governed by applicable state or federal statute and regulations.

12.6 LEAVE OF ABSENCE

A leave of absence is a period off work granted by the Participating Employer at a subscriber's request during which he or she is still considered to be employed and is carried on the employment records of the Participating Employer. A leave can be granted for any reason acceptable to the Participating Employer.

If granted a non-FMLA leave of absence by the Participating Employer, a subscriber may continue coverage for up to 90 days. Premiums must be paid through the Participating Employer in order to maintain coverage during a leave of absence.

12.7 STRIKE, LOCKOUT OR LABOR DISPUTE

If the subscriber's compensation includes group health coverage for which the premiums are paid in full or in part by the Group or each Participating Employer, or are paid by payroll deduction, the subscriber may pay the full amount of the premium directly to the Group whenever the subscriber's compensation is suspended or terminated directly or indirectly as the result of a strike, lockout, or other labor dispute for a period not to exceed 6 months.

During the period of the strike, lockout, or other labor dispute the Plan will not be altered or changed, except that premiums may change in accordance with the provision of the policy.

The continuation of coverage will be on a monthly renewal basis until the earlier of the following:

a. The end of the period for which the last premium is paid
b. A subscriber accepts full-time employment with another employer
c. The end of the 6-month continuation coverage period

SECTION 13. 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"). Members should check with the Participating Employer to determine if this section is applicable.

13.1 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 or Participating Employer for more information.

13.2 INFORMATION ABOUT THE PLAN AND BENEFITS

Subscribers may examine, without charge, at the Participating Employer's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts, collective bargaining agreements (if applicable), updated summary plan description, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (if any). This information can be obtained by written request. The Participating Employer may make a reasonable charge for the copies.

Subscribers are entitled to receive a summary of the Plan's annual financial report, if any is required by ERISA. The Participating Employer is required by law to furnish each subscriber with a copy of this summary annual report.

13.3 CONTINUATION OF GROUP HEALTH PLAN COVERAGE

Subscribers are entitled to continue healthcare coverage for themselves or their dependents if coverage under the Plan is lost as a result of a qualifying event. Members may have to pay for such coverage. Members should review this handbook and the documents governing the Plan regarding the rules governing continuation coverage rights.

Members are entitled to reduction or elimination of exclusionary periods if they have creditable coverage from another plan. A certificate of creditable coverage will be provided, free of charge, from the Plan when coverage is lost, when one becomes entitled to elect COBRA continuation coverage, when COBRA continuation coverage ceases, upon request before loss of coverage, or upon request up to 24 months after loss of coverage. Without evidence of creditable coverage, members may be subject to exclusion periods under the Plan.

13.4 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 Participating Employer, Group or any other person, may fire or discriminate against a subscriber in any way to prevent him or her from obtaining a benefit or exercising rights under ERISA.

13.5 ENFORCEMENT OF RIGHTS

If a claim for benefits is denied or no action is taken, in whole or in part, a member has 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 members can take to enforce these rights. For instance, if a copy of plan documents or the latest annual report from the Participating Employer is requested from the Participating Employer and not received within 30 days, a member may file suit in federal court. In such a case, the court may require the Participating Employer to provide the materials and pay the member up to $110 a day until he or she receives the materials, unless the materials were not sent because of reasons beyond the control of the Participating Employer. If a claim for benefits is denied or no action is taken, in whole or in part, a member may file suit in state or federal court after exhausting the appeal process required by the Plan (see section 9.2). In addition, a member who disagrees with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order may file suit in federal court.

If plan fiduciaries misuse the Plan's money, or if a member is discriminated against for asserting his or her rights, the member 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 the member is successful, the court may order the person who has been sued to pay these costs and fees. If the member loses, the court may order him or her to pay these costs and fees, (e.g., if it finds the claim is frivolous).

13.6 ASSISTANCE WITH QUESTIONS

For questions about this section or members' rights under ERISA, or for assistance obtaining documents from the Participating Employer, members should contact the Employee Benefits Security Administration, U.S. Department of Labor, 300 Fifth Avenue, Suite 1110, Seattle, Washington, 98104, telephone 206-757-6781, or the Office of Participant Assistance, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington D.C. 20210, telephone 866-444-3272. Members may also obtain publications about their rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

SECTION 14. MEMBERS' RIGHTS AND RESPONSIBILITIES

The following is an outline of Moda Health's policy on members' rights and responsibilities:

Members have the right to:

a. Be treated with respect and recognition of their dignity and need for privacy.
b. Have access to urgent and emergency services, 24 hours a day, 7 days a week.
c. Know what their rights and responsibilities are. Members will be given information about the Plan and how to use it, and about the providers who will care for them. This information will be provided in a way that members can understand.
d. Obtain a list of disclosure items in paper or electronic format from Moda Health, such as health benefit plan information, provider information, women's health and cancer rights, mental health coverage, pharmacy benefit and confidentiality of health information, by visiting myModa or by contacting Customer Service.
e. Participate in decision making regarding their healthcare. This includes a discussion of appropriate or medically necessary treatment options for their conditions, whether or not the cost or benefit is covered by Moda Health, and the right to refuse care and to be advised of the medical result of their refusal.
f. Receive services as described in this handbook.
g. Have their medical and personal information remain private. Personal information will be handled in compliance with state and federal law, and will be given to third parties only as necessary to administer the Plan, as required by law, or as permitted by the member.
h. File a grievance or appeal about any aspect of the Plan and to receive a timely response.
i. Obtain free language assistance services, including verbal interpretation services, when communicating with Moda Health.
j. Have a statement of wishes for treatment, known as an Advanced Directive, on file with their professional providers. Members also have the right to have a power of attorney, which allows a member to give someone else the right to make healthcare choices when the member is unable to make these decisions.
k. Make suggestions regarding Moda Health's policy on members' rights and responsibilities.

Members have the responsibility to:

a. Read this handbook to make sure they understand the Plan. Members are advised to call Customer Service with any questions.
b. Treat all providers and their staff with courtesy and respect.
c. Provide all the information needed for their provider to provide good healthcare.
d. Participate in making decisions about their medical care and forming a treatment plan.
e. Follow instructions for care they have agreed to with their provider.
f. Present their medical identification card when seeking medical care.
g. Use urgent and emergency services appropriately.

h. Use urgent and emergency services appropriately.
i. Notify providers of any other health or insurance policies that may provide coverage.
j. Reimburse Moda Health from any third party payments they may receive.
k. Keep appointments and be on time. If this is not possible, members must call ahead to let the provider know they will be late or cannot keep their appointment.
l. Seek regular health checkups and preventive services.
m. Provide adequate information to Moda Health to properly administer benefits and resolve any issues or concerns that may arise.

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

EXHIBIT A – PRIOR AUTHORIZATION GUIDELINES

AUTHORIZATION INFORMATION

Authorization requests may be phoned in toll-free to 800-258-2037 or faxed to 503-243-5105.

AUTHORIZATION REQUEST REQUIREMENTS

The following information should be included with a prior authorization request

- All pertinent patient information (subscriber, ID #, group #, relation to subscriber, and patient's birth date)
- The name of the facility where the procedure is to be performed
- The date of the procedure or date of admission
- Full name of surgeon's or specialist
- CPT & ICD (numeric only) codes
- Length of stay (indicate if outpatient)
- Chart notes and any other supporting documentation

SERVICES THAT DO NOT REQUIRE AUTHORIZATION

- Aspiration
- Biopsies
- Bone mineral density studies, diagnostic
- Brachytherapy for breast cancer
- Cardiovascular Stress Test
- Colonoscopy with medical diagnosis (not virtual)
- Colonoscopy with routine diagnosis, including family history diagnosis (not virtual)
- Diabetic Shoes (unless more than $500 and/or more than 1 pair per year)
- ECG, EKG
- Echocardiography
- EEG
- EMG CPT: 95870
- Infertility treatment
- Kidney dialysis
- Needle biopsy
- Punch biopsy
- Routine lab tests
- Trigger point injections
- Ultrasound
- X-rays

SERVICES THAT REQUIRE AUTHORIZATION

The following is a complete list of services and supplies that require authorization to determine medical necessity or plan benefit limitations.

COSMETIC PROCEDURES

Potentially cosmetic procedures may be an exclusion unless medical necessity has been established.

- Abdominoplasty
- Blepharoplasty and/or brow lift
- Botox injections
- Breast surgery - augmentation or reduction
- Dermabrasion
- Hormone related conditions
- Intralesional Injections (i.e., Kenalog)
- Laser treatment (except for retinopathy)
- Lipectomy
- Otoplasty
- Panniculectomy
- Port wine stain treatment
- Rhinoplasty
- Scar revisions (includes Kenalog injections)
- Silicone breast implant removal
- Varicose vein surgery/sclerotherapy

ORAL/MAXILLOFACIAL

- TMJ surgical splints
- Treatment of dental accidents
- Orthognathic services
- TMJ surgeries

DIAGNOSTIC PROCEDURES

- Genetic Testing
- RAST allergy testing
- Positron emission tomography (PET) scans
- Single photon emission computed tomography (SPECT) scans
- CT scans,(including computed tomography angiogram (CTA)
- MRI (including MRA, MRS, MRM)
- Nuclear cardiology imaging studies
- fMRI
- Upper endoscopies
- Sleep studies
- Virtual colonoscopy

EQUIPMENT/BRACES/DEVICES/APPLIANCES/SUPPLIES

- Airway clearance devices (chest percussors, vests, etc.)
- Augmentative communication device and system
- Bone growth stimulator
- Braces/Orthotics over $3,000 (except custom-made foot orthotics)
- Continuous glucose monitor
- Custom compression stockings over $500
- Custom/special seating system
- Custom wheelchair (also repairs over $500)
- Dynasplint/JAS (or other mechanical stretching device)
- Enteral feedings/nutritional formulas
- External wearable cardiac defibrillator
- Gradient pressure aid
- Hospital bed
- Insulin pump
- Intrapulmonary percussive ventilation
- INR Monitor, for home use
- Light box
- Wound vac (including wound warming cover)
- Low air loss products
- Low air loss products
- Muscle stimulator
- Nebulizer, portable over $300
- Oxygen (initial certification only)
- Patient lift
- Phototherapy lights (for dermatologic diagnosis)
- Power wheelchair/scooter (also repairs over $500)
- Prosthetics (except breast prosthetics)
- Sonic Accelerated Fracture Healing System
- Spinal cord stimulator
- Trapeze

EAR/NOSE/THROAT PROCEDURES

- Cochlear implantation/removal
- Otoplasty
- Rhinoplasty
- Septo-rhinoplasty
- Uvulopalatopharyngoplasty (UPPP)/Uvulectomy

EXPERIMENTAL OR INVESTIGATIONAL

- Active Cooling Devices (i.e., Game Ready)
- Anodyne Therapy System
- Automated, noninvasive nerve conduction study (e.g. NC-Stat)
- Balloon Sinuplasty (as standalone procedure)
- Bronchial Thermoplasty (Alair)
- Carotid Sinus Baroreflex Stimulation System (Rheos)
- Computer Assisted Navigation for musculoskeletal procedures
- Cryoablation of Breast Fibroadenomas
- Dynamic spine stabilization (Dynesys)
- ExMI (Extracorporeal Magnetic Innervation)
- Intradiscal Electrothermal Therapy (IDET)
- High Density Lipid Profile
- Home Interferential Muscle Stimulator
- Microcurrent Stimulators (MENS) (e.g. Alpha Stim unit)
- Micronutrient Testing
- Mobile Outpatient Cardiac Telemetry (MOCT)
- Nucleoplasty
- Ossatron/Orthotripsy/ESWT (extracorporeal shock wave therapy)
- Platelet Rich Plasma Injections
- Prolotherapy
- Percutaneous Lumbar Discectomy and Laser- assisted Disc Decompression
- Quantitative Sensory Testing
- Saliva Hormone Testing
- Sublingual Immunotherapy (SLIT)
- Somnoplasty™/Coblation
- Tissue Grafts/Mesh (Biologic engineered from human or xenograft source)
- Thermal Imaging/Thermography
- Transcranial Magnetic Stimulation
- Vertebral Axial Decompression

HOME SERVICES

- Home health services
- Home infusion services
- Hospice care
- Long-term facility care
- Palliative care

IMMUNOTHERAPY/ALLERGY AND INJECTIONS

Prior authorization is required for more than 56 units of CPT 95165 (56 units = 2 treatment sets at 28 doses per treatment set)

IMMUNIZATIONS

- Zostavax for under age 60
- Rabies Vaccine

INFUSION SERVICES (OUTPATIENT)

New FDA approved drugs are subject to review and may be subject to additional coverage requirements or limits established by the Plan.

- Alglucosidase Alfa (Lumizyme)
- Alpha 1 Proteinase Inhibitor (GLASSIA)
- Amevive Infusion
- Belimumab (Benlysta)
- Bendamustine (Treanda)
- Bevacizumab (Avastin)
- Brentuximab (Adcetris)
- Bortezomib (Velcade)
- Cabazitaxel (Jevtana)
- Cetuximab (Erbitux)
- Eribulin Mesylate (Halaven)
- Denosumab (Xgeva and Prolia)
- Ipilimumab (Yervoy)
- Iron
- Intravenous Immune Globulin (IVIG)
- Lumizyme (Pompe Disease)
- Orencia
- Paclitaxel Protein Bound (Abraxane)
- Palonosetron (Aloxi)
- Pamidronate (Aredia)
- Panitumumab (Vectibix)
- Pegloticase (Krystexxa)
- Pemetrexed (Alimta)
- Provenge (Sipuleucel-T)
- Reclast and Zometa (Zoledronic acid)
- Remicade Infusion
- Rituximab (for rheumatoid arthritis)
- Soliris
- Trastuzumab (Herceptin)
- Tysabri (Natalizumab)

INJECTABLES

New FDA approved drugs are subject to review and may be subject to additional coverage requirements or limits established by the Plan.

- Aflibercept (Eylea)
- Aranesp
- Arixtra
- Kineret
- Leukine
- Neulasta

- Avonex
- Betaseron
- Botox
- Cimzia
- Copaxone
- Enbrel
- Epogen
- Forteo
- Growth Hormone
- Hepsara
- Hydroxyprogesterone Caproate (Makena)
- Humira
- Infergen
- Neupogen
- Intron A
- Pegasys
- Peg-Intron
- Pegaptanib Sodium (Macugen)
- Ranibizumab (Lucentis)
- Rebetron
- Rebig
- Remodulin
- Somavert
- Synagis
- Xolair

INPATIENT STAY - ALL ADMISSION
Including substitution of care for hospitalization or other institutional expenses

INPATIENT REHABILITATION

LONG TERM CARE FACILITY AFTER HOSPITALIZATION

PAIN MANAGEMENT

- Epidural pain pump insertion
- Multidisciplinary pain team evaluation at Progressive Rehab
- Spine injections for chronic back pain
- Spinal Cord Stimulator (trial and permanent placement
- Synvisc, Supartz, Hyalgan, Orthovisc, Euflexxa Injections (all viscosupplementation)

PHARMACEUTICAL
Self-administered anti-cancer medications.

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

In addition to those drugs included in the current prior authorization list on myModa, prior authorization is required for:

- Retail prescriptions with a net cost over $1,000 for a 30-day supply
- Mail-order prescriptions with a net cost over $3,000
- All specialty medications
- Compounded medications with a net cost over $150 for a 30-day supply
- Claims for drugs purchased outside of the United States and its territories other than for emergency or urgent care situations
- Early refill of drugs for travel outside of the United States more than once every 6 months

REHABILITATIVE AND RECUPERATIVE SERVICES

Outpatient visits for physical therapy, occupational therapy, and speech therapy require authorization prior to the 26th visit.

Chronic illness programs, including but not limited to programs listed below, require prior authorization:

- Cardiac rehabilitation
- Pulmonary rehabilitation
- Multidisciplinary pain team evaluation at progressive Rehab

REPRODUCTIVE SERVICES

- DNA testing
- Genetic testing

RESIDENTIAL PROGRAMS FOR CHEMICAL DEPENDENCY AND MENTAL HEALTH

SKILLED NURSING FACILITY

SURGERY – ALL INPATIENT ELECTIVE SURGERIES AND PROCEDURES

SURGERY/TREATMENT – OUTPATIENT

- All outpatient surgeries on this prior authorization list
- Cartilage Transplants of the knee
- Prophylactic surgery (e.g. mastectomy)
- Thoracic Sympathectomy (for hyperhidrosis)

- Capsule Endoscopy
- Circumcision after 3 months of age
- Eye surgery for cataracts with implant of intraocular telescopic lens
- Hyperbaric Oxygen Therapy
- Neck/back/spine surgeries
- Kyphoplasty/Vertebroplasty
- Stereotactic Radiosurgery (i.e. Gamma Knife
- Outpatient Arthroscopies
- Hip, knee, shoulder surgeries

TRANSPLANTS

- All transplants except cornea
- Donor services

For help, call us directly at 866-940-0358.
(En Español: 888-786-7461)

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modahealth.com