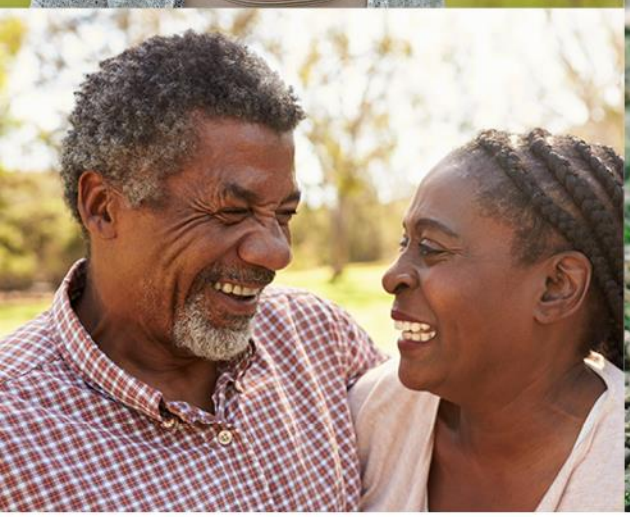

Alaska Group Medical Plan

Group Name
Endeavor Select Silver 2500

Effective Date: Effective Month 1, 2022
Group Number: Group Number

Health plans in Alaska provided by Moda Health Plan, Inc.
Delta Dental is a trademark of Delta Dental Plans Association

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SECTION 1. WELCOME

Moda Health is pleased to have been chosen by the Group as its preferred provider organization (PPO) plan. This handbook is designed to provide members with important information about the Plan's benefits, limitations and procedures.

Members may direct questions to one of the numbers listed in section 2.1 or access tools and resources on Moda Health's personalized member website, Member Dashboard, at www.modahealth.com. The Member Dashboard is available 24 hours a day, 7 days a week allowing members to access plan information whenever it's convenient. If an interpreter is necessary, Customer Service will coordinate the services of an interpreter over the phone.

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

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

SECTION 2. MEMBER RESOURCES

2.1 CONTACT INFORMATION

Moda Health Website (log in to the **Member Dashboard**)
www.modahealth.com
Includes many helpful features, such as:
- Find Care (use to find an in-network provider)
- Prescription price check tool and formulary (medication cost estimates and benefit tiers)
- Prior authorization lists (services and supplies that may require authorization)
- www.modahealth.com/medical/referrals

Medical Customer Service Department
Toll-free 888-873-1395
En Español 888-786-7461

Behavioral Health Customer Service Department
Toll-free 888-217-2373

Dental Customer Service Department
Toll-free 888-374-8906

Disease Management and Health Coaching
Toll-free 855-466-7155

Hearing Services Customer Service
TruHearing
Toll-free 866-202-2178

Virtual Care preferred vendor
CirrusMD
modahealth.com/cirrusmd

Pharmacy Customer Service Department
Toll-free 844-235-8017

Vision Care Services Customer Service Department
Toll-free 800-877-7195

Telecommunications Relay Service for the hearing impaired
711

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

Endeavor Select includes:
First Choice Health Network in Alaska
https://www.fchn.com/providersearch/moda-ak

2.2 MEMBERSHIP CARD

After enrolling, members will receive ID (identification) cards that will include the group and identification numbers. Members will need to present the card each time they receive services. Members may go to the Member Dashboard or contact Customer Service to replace a lost ID card.

2.3 NETWORKS

See Network Information (Section 5) for detail about how networks work.

Medical networks
Endeavor Select

Dental network
Delta Dental Premier

Pharmacy network
Navitus

Vision network
VSP

2.4 CARE COORDINATION

2.4.1 Care Coordination

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

The Plan will coordinate access to a wide range of services spanning all levels of care depending on the member's needs, including medical travel support to a preferred provider (see 7.7.4). Having a registered nurse, licensed clinical social worker or behavioral health clinician available to coordinate these services ensures improved and safe delivery of healthcare services to members and their professional providers.

2.4.2 Disease Management

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

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

Contact Disease Management and Health Coaching for more information.

2.4.3 Behavioral Health

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

2.5 OTHER RESOURCES

Additional member resources providing general information about the Plan can be found in Section 12 and Section 14.

SECTION 3. SCHEDULE OF BENEFITS

This section is a quick reference summarizing the Plan's benefits.

It is important to also check the Benefit Description (Section 7) for more details about any limitations or requirements. Link directly there from the Details column of the table below.

The details of the actual benefits and the conditions, limitations and exclusions are contained in the sections that follow. Prior authorization may be required for some services (see section 6.1). An explanation of important terms is found in Section 16.

Cost sharing is the amount members pay. See Section 4 for more information, including explanation of deductible and out-of-pocket maximum. For services provided out-of-network, members are also responsible for any amount over the maximum plan allowance.

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	**$2,500**	**$5,000**
Maximum annual deductible per family	**$5,000**	**$10,000**
Annual out-of-pocket maximum per member	**$8,550**	**$45,000**
Maximum annual out-of-pocket maximum per family	**$17,100**	**$90,000**

Services	**Cost Sharing** (Deductible applies unless noted differently)		**Section in Handbook & Details**
	In-network	**Out-of-network**†	
Urgent & Emergency Care			
Ambulance Transportation	30% In-network deductible and out-of-pocket maximum apply		Section 7.2.1
Non-emergent Air Ambulance Services	30%	50%	Section 7.2.1
Commercial Transportation	30%	30% (in-network deductible and out-of-pocket maximum apply)	Section 7.2.2 One-way for sudden, life-endangering medical condition

Services	Cost Sharing (Deductible applies unless noted differently)		Section in Handbook & Details
	In-network	Out-of-network†	
Emergency Room Facility (includes ancillary services)	$250 per visit, then 30% In-network deductible and out-of-pocket maximum apply		Section 7.2 and 7.2.4 No copay if covered hospitalization immediately follows emergency room use
ER professional or ancillary services billed separately	30% In-network deductible and out-of-pocket maximum apply		No deductible for diagnostic x-ray and lab
Urgent Care Office Visit	$85 per visit, no deductible	50%	Section 7.2.5
Medical Transportation	30%	30%	Section 7.2.3 2 round-trip tickets per year
Preventive Services			
Services as required under the Affordable Care Act, including the following:	No cost sharing	50%	Section 7.3 See section for frequency and age limitations
Colonoscopy	No cost sharing	50%	Section 7.3.1 One per 10 years, age 45+
Contraception	No cost sharing	50%	Section 7.3.2
Hearing Screening	No cost sharing	50%	Section 7.3.4 Initial screening within 30 days of birth Additional tests up to age 24 months
Immunizations	No cost sharing	50%	Section 7.3.3
Mammogram	No cost sharing	50%	Section 7.3.8 One age 35 - 39 One per year, age 40+
Preventive Health Exams	No cost sharing	50%	Section 7.3.5 3 exams age 2 - 4 One per year, age 5+
Well-Baby Exams	No cost sharing	50%	Section 7.3.7 First 24 months of life
Women's Exam & Pap Test	No cost sharing	50%	Section 7.3.8 One per year
Vision Screening	No cost sharing	50%	Section 7.3.4 Age 3 - 5

Services	Cost Sharing (Deductible applies unless noted differently)		Section in Handbook & Details
	In-network	Out-of-network†	
Other Preventive Services including:			
Diagnostic X-ray & Lab	30%, no deductible when outpatient	50%	
Prostate Rectal Exam	$35 per visit, no deductible	50%	Section 7.3.6 One per year, age 40+
Prostate Specific Antigen (PSA) Test	30%, no deductible when outpatient	50%	
Outpatient Services			
Acupuncture	$35 per visit, no deductible	50%	Section 7.4.1 24 visits per year
Anticancer Medication	30%	50%	Section 7.4.2
Applied Behavior Analysis	30%	50%	Section 7.4.3
Biofeedback	30%	50%	Section 7.4.4 10 visit lifetime maximum
Dental Care			Section 7.4.7 Under age 19 Frequency limits apply to some services
Diagnostic & Preventive	No cost sharing	50%	
Minor restorative services	30%	50%	
Other dental services	50%	50%	
Orthodontia	50%	50%	When medically necessary
Dental Injury	30%	50%	Section 7.4.8
Diabetes Services	30%	50%	Section 7.4.10 Supplies covered under DME and Pharmacy benefits
Diagnostic Procedures, including x-ray & lab	30%, no deductible when outpatient	50%	Section7.4.11
Advanced Imaging procedures	30%	50%	Section 7.4.11
Infusion Therapy (Home or Outpatient)	30%	50%	Section 7.4.15
Kidney Dialysis	30%	50%	Section 7.4.16
Massage Therapy	$35 per visit, no deductible	50%	Section 7.4.17 24 visits per year
Mental Health Services			Section 7.4.19
Office Visit	$85 per visit, no deductible	50%	
Other Services	30%	50%	

Services	Cost Sharing (Deductible applies unless noted differently)		Section in Handbook & Details
	In-network	Out-of-network†	
Nutritional Therapy	30%	50%	Section 7.4.20
Office & Home Visits			Section 7.4.21 See also Virtual Care Visits under Other Services
PCP Visits (including naturopath visits)	$35 per visit, no deductible	50%	
Specialist Visits	$85 per visit, no deductible	50%	Section 7.4.21
Psychological or Neuropsychological Testing	$35 per visit, no deductible	50%	Section 7.4.24 12 hours per year
Rehabilitation & Habilitation	$85 per visit, no deductible	50%	Section 7.4.25 45 sessions per year Limits apply separately to rehabilitation and habilitation services
Spinal Manipulation	$35 per visit, no deductible	50%	Section 7.4.26 24 visits per year
Substance Use Disorder Services			Section 7.4.27
Office Visit	$85 per visit, no deductible	50%	
Other Services	30%	50%	
Surgery & Invasive Diagnostic Procedures	30%	50%	Section 7.4.28
Therapeutic Injections	30%	50%	Section 7.4.29
Therapeutic Radiology	30%	50%	Section 7.4.30
Inpatient & Residential Facility Care			
Diagnostic Procedures, including x-ray and lab	30%	50%	Section 7.5.1
Hospital Physician Visits	30%	50%	Section 7.5.3
Inpatient Care	30%	50%	Section 7.5.2
Rehabilitation	30%	50%	Section 7.5.6 30 days per year
Residential Mental Health & Substance Use Disorder Treatment Programs	30%	50%	Section 7.5.7
Skilled Nursing Facility Care	30%	50%	Section 7.5.8 60 days per year
Substance Use Disorder Detoxification	30%	50%	Section 7.5.9
Surgery	30%	50%	Section 7.5.10
Transplants			Section 7.5.13 Includes donor costs
Center of Excellence facilities	30%	N/A	
Other facilities	Not covered	Not covered	
Travel, Lodging & Meals	30%	30%	$7,500 per transplant

Services	Cost Sharing (Deductible applies unless noted differently)		Section in Handbook & Details
	In-network	Out-of-network†	
Maternity Services			
Breastfeeding			Section 7.6.2
Support & Counseling	No cost sharing	50%	
Supplies		No cost sharing	
Maternity	30%	50%	Section 7.6
Other Services			
Durable Medical Equipment, Supplies & Appliances	30%	50%	Section 7.7.1 Limits apply to some DME, supplies, appliances
Home Healthcare	30%	50%	Section 7.7.2 130 visits per year
Hospice Care			Section 7.7.3
Home Care	30%	50%	
Inpatient Care	30%	50%	10 days
Respite Care	30%	50%	240 hours
Medical Travel Support			Section 7.7.4
Procedures	No cost sharing	N/A	Through SurgeryCare
Travel and Lodging	No cost sharing	N/A	
Procedures	30%	N/A	Through OHSU
Travel and Lodging	No cost sharing	N/A	
Virtual Care Visits	$25 per visit, no deductible	50%	Section 7.7.6
Through CirrusMD	No cost sharing	N/A	Log on via modahealth.com/cirrusmd
Pharmacy			
Prescription Medication	A member who uses an out-of-network pharmacy must pay any amounts charged above the MPA		Section 7.8 Up to 90-day supply for retail and mail order One copay for each 30-day supply
Retail Pharmacy			No deductible
Value Tier	No cost sharing	No cost sharing	
Select Tier	$25	$25	
Preferred Tier	$70	$70	
Nonpreferred Tier	$150	$150	
Mail Order Pharmacy		Must use a Moda-designated mail order pharmacy	No deductible
Value Tier	No cost sharing		
Select Tier	$75		
Preferred Tier	$210		
Nonpreferred Tier	$450		

Services	Cost Sharing (Deductible applies unless noted differently)		Section in Handbook & Details
	In-network	Out-of-network†	
Specialty Pharmacy		Must use a Moda-designated specialty pharmacy	Up to 30-day supply per prescription for most medications
Preferred Specialty	30%		
Nonpreferred Specialty	50%		
Anticancer Medication	30%	30% Must use a Moda-designated pharmacy for mail order and specialty	Section 7.4.2 Pharmacy tier deductible applies
Vision Care			
Pediatric Vision Care			Section 7.9.1 Under age 19 No deductible
Exam	No cost sharing	50%	One per year
Lenses & frames or contacts	No cost sharing	50%	One pair per year Frames from the Otis & Piper Eyewear collection only
Optional Lenses and Treatments	No cost sharing	50%	
Low vision evaluation	No cost sharing	50%	One every year
Low vision services	No cost sharing	50%	4 visits every 5 years for follow up care
Low vision aids	No cost sharing	50%	One low vision aid per year and one pair of high power spectacles per year
Adult Vision Services			Section 7.9.2 Age 19+ No deductible
Well-vision exam	$10	50%	One per year
Lenses & frames	$25	50%	One pair lenses per year and one pair frames every 2 years In-network frames up to $130 maximum
Contacts (elective) including contact lens exam	No cost sharing	50%	Once per year, in lieu of frames and lenses In-network up to $130 maximum

Services	Cost Sharing (Deductible applies unless noted differently)		Section in Handbook & Details
	In-network	Out-of-network†	
Contacts (medically necessary) including contact lens exam	$25	50%	In lieu of frames and lenses
Low vision testing	No cost sharing	50%	Low vision tests twice every 2 years
Low vision aids	25%	50%	In-network up to $1,000 maximum every 2 years for all services, testing and aids.
Hearing Coverage			
Hearing exam	20%, no deductible	20%, no deductible	Section 7.10 Ear examination once per 2 years. Other services, including hearing exams, once in a 3-year period. Hearing aids subject to a $3,000 maximum every 3 years
Hearing testing & hardware	20%, no deductible	20%, no deductible	

† All professional services provided in Alaska will be paid at the in-network benefit level, subject to the in-network deductible, and count toward the in-network out-of-pocket maximum. In Alaska, all hospital services except those provided by out-of-network hospitals located within 50 miles of an in-network hospital will be reimbursed at the in-network benefit level, subject to the in-network deductible, and count toward the in-network out-of-pocket maximum.

SECTION 4. PAYMENT & COST SHARING

4.1 DEDUCTIBLES

Every year, members will have to pay some expenses before the Plan starts paying. This is called meeting or satisfying the deductible. The deductible is lower when paid as an in-network benefit. Members must pay the entire covered expenses until they have spent the deductible amount, unless the Plan specifically states otherwise. Then the Plan begins sharing costs with the member.

	Covered expenses accrue toward the deductible	
	In Alaska	**Outside of Alaska**
In-network providers	In-Network deductible	
In-network hospital		
Out-of-network providers	In-Network deductible	Out-of-Network deductible
Out-of-network hospitals	In-Network deductible (if located more than 50 miles from an in-network hospital)	Out-of-Network deductible
Providence hospitals located within 50 miles of an Alaska Regional hospital	Out-of-Network deductible	

Once a family member has met their per member deductible, the Plan will begin paying benefits for that member's covered expenses, whether or not the entire family deductible has been met. The deductible amounts, and the amount a member pays after the deductible is met, are shown in Section 3. In-network and out-of-network services have separate deductibles. If more than one member of a family is covered, each individual member only has to pay their per member deductible until the total family deductible is reached.

Disallowed charges, copayments and manufacturer discounts and/or copay assistance programs do not apply to the annual deductible.

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 have to satisfy additional deductible after renewal through December 31st.

4.2 ANNUAL MAXIMUM OUT-OF-POCKET

The Plan helps protect members from very high medical costs. The out-of-pocket maximum is an upper limit on how much members have to pay for covered charges each year. Once a member has paid the maximum out-of-pocket amount, the Plan will pay 100% of covered services for that member for the rest of the year. If more than one member of a family is covered, the per member maximum applies only until the total family out-of-pocket maximum is reached, even if no single family member has reached the per member maximum. The in-network and out-of-network out-of-pocket maximums add up 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 have to pay additional out-of-pocket costs after renewal through December 31st.

Expenses accumulate toward the annual out-of-pocket maximum as shown:

<table>
<tr><th rowspan="2"></th><th colspan="2">Out-of-pocket covered expenses accrue toward</th></tr>
<tr><th>In Alaska</th><th>Outside of Alaska</th></tr>
<tr><td>In-network providers</td><td colspan="2" rowspan="2">In-network out-of-pocket maximum</td></tr>
<tr><td>In-network hospital</td></tr>
<tr><td>Out-of-network providers</td><td>In-network
out-of-pocket maximum</td><td>Out-of-network
out-of-pocket
maximum</td></tr>
<tr><td>Out-of-network hospitals</td><td>In-network out-of-pocket maximum
(if located more than 50 miles from an in-network hospital)</td><td>Out-of-network
out-of-pocket
maximum</td></tr>
<tr><td>Providence hospitals located within 50 miles of an Alaska Regional hospital</td><td colspan="2">Out-of-network out-of-pocket maximum</td></tr>
</table>

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

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

a. Cost containment penalties
b. Disallowed charges
c. Out-of-network vision benefits for members under age 19
d. Vision benefits for members over age 18
e. Hearing coverage benefits

4.3 PAYMENT

Expenses allowed by Moda Health are based upon the maximum plan allowance (MPA), which is a contracted fee for in-network providers. For out-of-network providers the MPA is an amount established, reviewed, and updated by a national database (see Section 16). Depending upon the Plan provisions, cost sharing may apply.

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

4.4 EXTRA-CONTRACTUAL SERVICES

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

After case management evaluation and analysis by Moda Health, extra-contractual services will be covered when agreed upon by a member and their professional provider and Moda Health. Any party can provide notification in writing and terminate such services.

The fact that the Plan has paid benefits for extra-contractual 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 extra-contractual services for the same member. All amounts paid for extra-contractual services under this provision shall be included in computing any benefits, limitations or cost sharing under the Plan.

SECTION 5. NETWORK INFORMATION

To receive maximum benefits members should seek service from in-network providers. Members will have higher out-of-pocket costs if they utilize providers who are not in the network. Remember to ask providers to send any lab work or x-rays to an in-network facility for the highest benefits. Services a member receives in an in-network facility may be provided by physicians, anesthesiologists, radiologists or other professionals who are out-of-network providers. An out-of-network provider has the right to bill the difference between the maximum plan allowance and the actual charge. This difference will be the member's responsibility in addition to any cost sharing, cost containment penalties and disallowed charges.

In-network benefits and out-of-network benefits are determined as shown:

<table>
<tr><td></td><td colspan="2">Reimbursement Benefit Level
(Deductible, Copayment, Coinsurance and Out-of-Pocket Maximum)</td></tr>
<tr><td></td><td>In Alaska</td><td>Outside of Alaska</td></tr>
<tr><td>In-network providers</td><td colspan="2" rowspan="2">In-Network Benefit</td></tr>
<tr><td>In-network hospital</td></tr>
<tr><td>Out-of-network providers</td><td>In-Network Benefit</td><td>Out-of-Network Benefit</td></tr>
<tr><td>Out-of-network hospitals</td><td>In-Network Benefit
(if located more than 50 miles from an in-network hospital)</td><td>Out-of-Network Benefit</td></tr>
<tr><td>Providence hospitals located within 50 miles of an Alaska Regional hospital</td><td colspan="2">Out-of-Network Benefit</td></tr>
</table>

Members may choose an in-network provider by using "Find Care" on the Member Dashboard and checking the First Choice website for providers in Alaska and the Private Healthcare Systems (PHCS) website for providers in states other than Alaska or by contacting Customer Service for assistance. Member ID cards will identify the applicable network(s).

Members should ask if their provider is participating with the specific network listed in section 5.1.1. Do not ask if the provider accepts Moda. There are many Moda Health networks. A provider may accept Moda insurance, but not be participating with the network for the Plan. Members may contact Customer Service for help finding an in-network provider.

5.1 GENERAL NETWORK INFORMATION

5.1.1 Networks

Medical network is Endeavor Select
Pharmacy network is Navitus
Dental network is Delta Dental Premier Network
Vision care network is VSP

5.1.2 Coverage Outside the Service Area for Children

If there is not an in-network provider within a 50-mile radius, plan benefits will be extended to enrolled children residing in the United States 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 50-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 50-mile radius of the child's residence
d. Out-of-network providers may bill members for charges over the maximum plan allowance for those services

In-network benefits are not available to a child residing outside the service area for the purpose of receiving treatment or benefits.

When an enrolled child moves outside the service area, members must contact Customer Service and their employer to update the address with Moda Health. The enrolled child will be eligible for out-of-area coverage the first day of the month following the date the address is updated in the system.

5.1.3 Out-of-Network Care

When members use healthcare providers that are not in-network, the benefit from the Plan is lower when paid at the out-of-network level described in Section 3. If there is no assignment of benefits, the member must pay the provider all charges at the time of treatment, and then file a claim to be reimbursed the out-of-network benefit. If the provider's charges are more than the maximum plan allowance, the member is responsible for paying those excess charges.

When receiving care at an in-network facility, ask to have related services (such as diagnostic testing, equipment and devices, telemedicine, anesthesia, surgical assistants) performed by in-network providers to ensure the highest benefit level. When out-of-network ancillary providers provide services at an in-network facility, in-network cost sharing will apply.

5.1.4 Care After Normal Office Hours

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

5.2 Using Find Care

To search for in-network providers, members can log in to their Member Dashboard account at modahealth.com and click on Find Care.

Search for a specific provider by name, specialty or type of service, or look in a nearby area using ZIP code or city.

5.2.1 Primary Care Providers

To find a PCP:

a. Choose the “Primary Care Provider” option under the Specialty drop down menu
b. Enter ZIP code and Search

The search will bring up a list of PCPs.

5.2.2 DME Providers

Find a preferred DME provider:

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

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

SECTION 6. PRIOR AUTHORIZATION

Prior authorization is used to ensure member safety, encourage appropriate use of services and medications, and support cost effective treatment options for members. Moda Health may encourage members to use a preferred treatment center or provider. Services requiring prior authorization are evaluated using evidence based criteria that align with medical literature, best practice clinical guidelines and guidance from the FDA. Moda Health will authorize medically necessary services, supplies or medications based upon the member's medical condition.

When a professional provider suggests a type of service requiring authorization (see section 6.1.1), the member should ask the provider to contact Moda Health for prior authorization. Authorization for emergency hospital admissions must be obtained by calling Moda Health within 48 hours of the hospital admission (or as soon as reasonably possible). The hospital, professional provider and member are notified of the outcome of the authorization process by letter.

6.1 PRIOR AUTHORIZATION REQUIREMENTS

If a member fails to obtain prior authorization for inpatient or residential stays, urgent care, or for outpatient or ambulatory services when authorization is required, 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.

The prior authorization penalty does not apply toward the Plan's deductible or out-of-pocket maximum. The penalty will not apply in the case of an emergency admission.

A prior authorization for a covered service or supply on the basis of medical necessity will not be retroactively denied unless the prior authorization is based on materially incomplete or inaccurate information provided by or on behalf of the provider.

6.1.1 Services Requiring Prior Authorization

Many services within the following categories may require prior authorization.

a. Inpatient services and residential programs
b. Outpatient services
c. Rehabilitation including occupational therapy, physical therapy and speech therapy
d. Spinal manipulation or acupuncture services or massage therapy
e. Imaging services
f. Infusion therapy
g. Medications
h. Non-emergent air ambulance services

A full list of services and supplies requiring prior authorization is on the Moda Health website. This list is updated periodically, and members should ask their provider to check to see if a service or supply requires authorization. A member may obtain authorization information by contacting Customer Service. For mental health or substance use disorder services, contact Behavioral Health Customer Service.

6.1.2 Prior Authorization Limitations

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

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

Any limits or requirements that apply to authorized services will be described in the authorization letter that is sent to the provider and member. Members who are working with a Care Coordinator or Case Manager (see section 2.4) can also get help understanding how to access their authorized treatment from their Care Coordinator or Case Manager.

6.1.3 Second Opinion

Moda Health may recommend an independent consultation to confirm that non-emergency treatment is medically necessary. The Plan pays the full cost of the second opinion with any deductible waived.

SECTION 7. BENEFIT DESCRIPTION

The Plan covers services and supplies listed when medically necessary for diagnosis and/or treatment of a medical condition, as well as certain preventive services. The details of the different types of benefits and the conditions, limitations and exclusions are described in the sections that follow. An explanation of important terms is found in Section 16.

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

Many services require prior authorization. A complete list is available on the Member Dashboard or by contacting Customer Service. Failure to obtain required prior authorization will result in denial of benefits or a penalty. Services outside of any limitations in the authorization may also be denied. (See section 6.1 for prior authorization information.)

7.1 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. The Group has paid the member's premiums on time for the current month

Benefits are only payable after the service or supply has been provided. If an exclusion or limit applies, benefits may not be paid.

If a member is in a hospital inpatient on the day the policy with the Group is terminated, the Plan will continue to pay claims for covered services for that hospitalization until the member is discharged from the hospital or until inpatient care is no longer medically necessary, whichever comes first. In order for inpatient benefits to be extended, the policy with the Group cannot end due to fraud or an intentional misrepresentation of material fact and the member must have been enrolled on the Plan for more than 31 days and not have other health coverage that would have provided benefits if coverage under the Plan did not exist.

7.2 URGENT & EMERGENCY CARE

Care received outside of the United States is only covered for an urgent or emergency medical condition. Emergency services will be paid at the in-network benefit level. Information on how members can submit a claim when the provider does not submit a claim form on their behalf is found in section 11.1.

7.2.1 Ambulance Transportation

Licensed surface (ground or water) and emergent air ambulance transportation is covered for medically necessary transport to the nearest facility that has the capability to provide the necessary treatment. Medically necessary services and supplies provided by the ambulance are

also covered. This benefit only covers the member that requires transportation. Out-of-network ground ambulance providers may bill members for charges over the maximum plan allowance.

Non-emergent air ambulance services, including transfer from one facility to another as needed for the member's condition, are covered. Prior authorization is required.

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

7.2.2 Commercial Transportation

Limited to one-way air or surface transportation services provided by a licensed commercial carrier for a member only, when transportation is for a sudden, life-endangering medical condition that results in a hospital admission. The trip must begin at the location in Alaska where the member became ill or injured and end at the location of the nearest hospital equipped to provide treatment not available in a local facility. Transportation outside Alaska is limited to Seattle, Washington.

7.2.3 Medical Transportation

Limited to medically necessary round-trip air transportation services provided by a licensed commercial carrier for a member only. Transportation for a registered nurse or doctor may also be covered if medically necessary. A parent or legal guardian may accompany a member under the age of 18 who requires medically necessary air travel.

Travel is covered only to the nearest facility equipped to provide treatment not available in a local facility. This benefit is limited to a maximum of 2 round-trip tickets per member per year.

This benefit covers travel for:

a. one initial visit and one follow-up visit for therapeutic treatment
b. one visit for pre- or postnatal care and one visit for actual delivery
c. one pre- or post surgical visit and one visit for the actual surgery
d. one visit for each allergic condition

Prior authorization is required. Written certification from the attending physician must be submitted and travel must be approved in advance of the trip. Reimbursement is limited to the cost of commercial air fare based on the lowest fare available at the time of the reservation. Flight reservations should be made as far in advance as possible. Expenses or fees beyond the cost of the airline ticket are not covered.

7.2.4 Emergency Room Care

Members are covered for treatment of emergency medical conditions (as defined in Section 16) worldwide. A member who believes they have a medical emergency should call 911 or seek care from the nearest appropriate provider.

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

All claims for emergency services (as defined in Section 16) will be paid at the in-network benefit level. Out-of-network providers cannot balance bill members except when permitted by law. Using an in-network emergency room does not guarantee that all providers working in the emergency room and/or hospital are also in-network providers.

If a covered hospitalization immediately follows emergency services, emergency room facility copayments will be waived. All other applicable cost sharing remains in effect.

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

If a member's condition requires hospitalization in an out-of-network facility outside of Alaska or one located within 50 miles of an in-network hospital in Alaska, the attending physician and Moda Health's medical director will monitor the condition and determine when the transfer to an in-network facility can be made. The Plan does not provide the in-network benefit level for care beyond the date it is determined the member can be safely transferred.

The in-network benefit level is not available if a member goes to a Providence hospital that is within 50 miles of an Alaska Regional hospital in Alaska or an out-of-network provider outside of Alaska for care other than emergency medical care. The following are examples of services that are not for treatment of emergency medical conditions and members should not go to an emergency room for such services:

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

7.2.5 Urgent Care

Short-term medical care provided by an urgent care facility (as defined in Section 16) for minor but urgent medical conditions that do not pose a significant threat to life or health at the time the services are rendered is covered. The member must be actually examined by a professional provider.

Visits at walk-in clinics and immediate care facilities are covered under the office visit benefit (section 7.4.21). Immediate care, express care or walk-in care refers to primary care or specialist care that is on-demand and does not require an appointment. Facilities that provide such on-demand care are not urgent care facilities unless their claim billing includes the CMS place of service code that is specific for an urgent care facility.

7.3 PREVENTIVE SERVICES

As required under the Affordable Care Act (ACA), certain services will be covered at no cost to the member when performed by an in-network provider (see Section 3 for benefits paid at the out-of-network level). Moda Health may use reasonable medical management techniques to determine the most medically appropriate cost effective option that is covered at no cost, as permitted by the ACA. This means that some services listed in section 7.3 below may be subject to member cost sharing:

a. Evidence-based services rated A or B by the United States Preventive Services Taskforce
b. Immunizations recommended by the Advisory Committee on Immunization Practices of the Center for Disease Control and Prevention (ACIP)
c. Preventive care and screenings recommended by the Health Resources and Services Administration (HRSA) for infants, children and adolescents (PERIODICITY SCHEDULE 2021.indd (aap.org)), and women (www.hrsa.gov/womensguidelines/)

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

Preventive services that meet the frequency and age limits in the ACA guidelines are covered.

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

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

7.3.1 Colorectal Cancer Screening

The following services, including related charges, for members age 45 and over:

a. One colonoscopy, including polyp removal, and pre-surgical exam or consultation every 10 years
b. One fecal DNA test every 3 years
c. One flexible sigmoidoscopy and pre-surgical exam or consultation every 5 years
d. One double contrast barium enema every 5 years
e. One CT colonography (virtual colonoscopy) every 5 years
f. One take-home package for fecal occult blood test or fecal immunochemical test every year

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

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

7.3.2 Contraception

All FDA approved contraceptive methods, including sterilization and counseling, and related office visits, are covered when prescribed by a professional provider. Female contraception, when delivered by an in-network provider and using the most medically appropriate cost effective option (e.g., generic instead of brand name), will be covered with no cost sharing. Surgery to reverse elective sterilization (vasectomy or tubal ligation) is not covered.

7.3.3 Immunizations

The Plan covers routine immunizations for members of all ages, limited to those recommended by the ACIP. Immunizations for the sole purpose of travel or to prevent illness that may be caused by a work environment are not covered, except as required under the Affordable Care Act.

7.3.4 Pediatric Screenings

At the frequency and age recommended by HRSA or USPSTF, or required by the state of Alaska, including:

a. An initial newborn or infant hearing screening performed by a professional provider within 30 days after the child's birth. If the initial screening determines that the child may have a hearing impairment, additional diagnostic hearing tests up to age 24 months are covered.

b. Routine vision screening to detect amblyopia, strabismus and defects in visual sharpness in children age 3 to 5.

c. Developmental and behavioral health screenings.

7.3.5 Preventive Health Exams

Covered according to the following schedule:

i. Newborn: One hospital visit
ii. Age 2 to 4: 3 exams
iii. Age 5 and above: One exam every year

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

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

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

Cost sharing applies to prostate rectal exam and PSA test. For members age 40 and over, one rectal exam and one PSA test is covered every year. The Plan also covers one rectal exam and one PSA test every year for members between the ages of 35 and 40 who are African-American or have a family history of prostate cancer.

7.3.7 Well-Baby Exams

Periodic health exams during a baby's first 24 months of life. Covered well-baby exams must be performed by a professional provider including a physician, a health aide, a nurse or a physician assistant. A well-baby exam includes a physical exam and consultation between the professional provider and a parent.

Routine diagnostic x-ray and lab work related to a well-baby exam are also covered and are subject to the standard cost sharing.

7.3.8 Women's Healthcare

One preventive women's healthcare visit per year, including pelvic and breast exams and a Pap test. Mammograms are limited to one between the ages of 35 and 39, and one per year age 40 and older.

Pap tests and breast exams, and mammograms for the purpose of screening or diagnosis in symptomatic or designated high risk women, are also covered when deemed necessary by a

professional provider. These services are covered under the office visit, x-ray or lab test benefit level if not performed within the Plan's age and frequency limits for preventive screening.

7.4 OUTPATIENT SERVICES

Many outpatient services require prior authorization (see section 6.1.1). All services must be medically necessary.

7.4.1 Acupuncture

Covered up to an annual visit limit. Services such as office visits or diagnostic services are not covered under this benefit. They are subject to the Plan's standard benefit for those services. Office visits by acupuncturists are considered specialist office visits. Acupuncture services must be prior authorized as medically necessary.

7.4.2 Anticancer Medication

Prescribed anticancer medications, including oral, intravenous (IV) or injected medications, are covered. Most anticancer medications may require prior authorization and be subject to specific benefit limitations. Specialty anticancer medications require delivery by a Moda-designated specialty pharmacy (see section 7.8.5). For some anticancer medications, members may be required to enroll in programs to ensure proper medication use and/or reduce the cost of the medication. More information is available on the Member Dashboard or by contacting Customer Service.

7.4.3 Applied Behavior Analysis (ABA)

ABA for autism spectrum disorder and the management of care provided in the member's home, a licensed health care facility or other setting as approved by Moda Health is covered. Services must be medically necessary and prior authorized, and the provider must submit an individualized treatment plan.

Coverage for applied behavior analysis does not include:

a. Services provided by a family or household member
b. Custodial or respite care, equine assisted therapy, creative arts therapy, wilderness or adventure camps, music therapy, neurofeedback, chelation or hyperbaric chamber
c. Services provided under an individual education plan (IEP) to comply with the Individuals with Disabilities Education Act
d. Services provided by the Department of Health and Social Services, other than employee benefit plans offered by the department

7.4.4 Biofeedback

Covered expenses are limited to treatment of tension or migraine headaches. Covered visits are subject to a lifetime limit.

7.4.5 Clinical Trials

Usual care costs for the care of a member who is enrolled in an approved clinical trial as defined in federal or state laws related to cancer or other life-threatening conditions, including leukemia, lymphoma, and bone marrow stem cell disorders are covered. Such costs will be subject to the same cost sharing that would apply if provided in the absence of a clinical trial.

Clinical trials are covered only if the member's treating physician determines that there is no clear superior noninvestigational treatment alternative, and available clinical or preclinical data

provide a reasonable expectation that the treatment provided in the clinical trial will be at least as effective as any noninvestigational alternative.

The following costs are covered:

a. Prevention, diagnosis, treatment and palliative care of a qualified medical condition
b. Medical care for an approved clinical trial that would otherwise be covered under the Plan if the medical care were not in connection with an approved clinical trial
c. Items or services necessary to provide an investigational item or service
d. The diagnosis or treatment of complications
e. A drug or device approved by the United States Food and Drug Administration (FDA) without regard to whether the FDA approved the drug or device for use in treating a member's particular condition, but only to the extent that the drug or device is not paid for by the manufacturer, distributor, or provider of the drug or device
f. Services necessary to administer a drug or device under evaluation in the clinical trial
g. Transportation for the member and one caregiver that is primarily for and essential to the medical care

The Plan does not cover:

a. A drug or device associated with the clinical trial that has not been approved by the FDA
b. Housing, companion expenses, or other nonclinical expenses associated with the clinical trial
c. An item or service provided solely to satisfy data collection and analysis and not used in the clinical management of the member
d. An item or service excluded from coverage in Section 8
e. An item or service paid for or customarily paid for through grants or other funding

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

7.4.6 Cochlear Implants

Cochlear implants are covered when medically necessary and prior authorized.

7.4.7 Pediatric Dental Care

Dental care is covered for members through the end of the month in which they reach age 19, including:

a. Diagnostic
    i. Diagnostic exams (including problem focused comprehensive examinations) once in any 6 month period
    ii. Limited examinations or re-evaluations twice in any benefit year
    iii. Full series or panoramic X-rays once in any 5-year period
    iv. Periapical X-rays not included in the full series for diagnosis
    v. Supplementary bitewing X-rays once in any 6 month period
    vi. An occlusal intraoral X-ray once in any 2 year period
    vii. Cephalometric films
    viii. Diagnostic casts other than those under the orthodontic benefits
    ix. Oral and facial photographic images on a case-by-case basis
    x. Interpretation of a diagnostic image by a dentist not associated with the capture of the image

    Other diagnostic services not mentioned in this section are not covered such as TMJ films, cone beam CT, viral culture, caries test, stains, immunofluorescence, nutritional or

tobacco cessation counseling, oral hygiene instruction, removal of fixed space maintainers and duplication and interpretation of records

b. Preventive
   i. Prophylaxis once in any 6 month period (may be eligible for additional cleanings if pregnant or diabetic). Adult prophylaxis for members age 12 and over, child prophylaxis for members under age 12
   ii. Topical fluoride treatment once in any 6 month period
   iii. Interim caries arresting medicament application twice per tooth per year
   iv. Sealant once in any 3-year period on unrestored occlusal surfaces of permanent molars
   v. Space maintainers, including re-cementation

c. Minor Restorative Services
   i. Amalgam and composite fillings for the treatment of decay
   ii. Re-cementation of inlays or crowns
   iii. Prefabricated stainless steel crowns for under age 15 one per tooth in any 5-year period
   iv. Protective restoration and pin retention per tooth
   v. Prefabricated porcelain/ceramic crown for a primary tooth once in any 5-year period

d. Endodontic
   i. Therapeutic pulpotomy. A separate charge for pulp removal done with a root canal or root repair is not covered.
   ii. Partial pulpotomy for apexogenesis on permanent teeth. A separate charge for pulp removal done with a root canal or root repair is not covered.
   iii. Pulpal therapy (resorbable filling) for primary incisor teeth up to age 6 and for primary molars and cuspids up to age 11 once per tooth per lifetime
   iv. Root canal therapy
   v. Retreatment of previous root canal therapy (at least 2 years after original root canal therapy)
   vi. Apexification or recalcification
   vii. Pulpal regeneration
   viii. Apicoectomy and periradicular surgery
   ix. Root amputation
   x. Hemisection

   Other endodontic services not mentioned in this section are not covered such as endodontic implant, intentional replantation, canal preparation, a separate charge for pulp capping and the subsequent retrograde filling by the same dentist within a 2-year period of an initial retrograde filling.

e. Periodontic
   i. Periodontal scaling and root planing once per quadrant in any 2-year period
   ii. Periodontal maintenance limited to 4 in any 12 month period combined with prophylaxis
   iii. Bone replacement grafts are covered once per quadrant in any 3-year period.
   iv. Full mouth debridement limited to once in any 2-year period
   v. Gingivectomy or gingivoplasty
   vi. Gingival flap procedure
   vii. Clinical crown lengthening
   viii. Osseous surgery
   ix. Pedicle soft tissue graft

x. Free soft tissue graft procedure (including donor site surgery)
xi. Subepithelial connective tissue graft procedures (including donor site surgery)
xii. Collection and application of autologous blood concentrate product once in any 3-year period when dentally necessary

Other periodontic services not mentioned in this section are not covered such as TMJ appliance and therapy, anatomical crown exposure and extra coronal splinting.

f. Oral Surgery
   i. Extractions (including surgical)
   ii. Coronectomy – intentional partial tooth removal
   iii. Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth
   iv. Alveoloplasty
   v. Removal of exostosis
   vi. Incision and drainage of abscess
   vii. Suture of recent small wounds up to 5 cm
   viii. Excision of pericoronal gingiva
   ix. Treatment of post-surgical complications

   Other oral surgery services not mentioned in this section are not covered such as treatment of closed fractures and separate charges for post-operative care done within 30 days following an oral surgery (with the exception of treatment of post-surgical complications listed above). Post-operative care is included in the charge for the original surgery.

g. Major Restorative Services
   i. Inlays are limited to the benefit for a filling
   ii. Onlays and crowns once per tooth in any 5-year period
   iii. Crown buildup once per tooth in any 5-year period
   iv. Core buildup, including pins, on permanent teeth in conjunction with a crown
   v. Prefabricated post and core once per tooth in any 5-year period
   vi. Crown repair on a case by case basis

   Other restorative services not mentioned in this section are not covered such as gold foil, provisional crown, post removal and temporary crown.

h. Prosthodontic
   i. Complete or partial dentures once per tooth site in any 5-year period
   ii. Dental implants when determined dentally necessary, at least 5 years after last cast restoration. If dental implants are not covered, the implant crown, bridge, denture or partial denture are covered subject to the Major Restorative or Prosthodontic benefit limits
   iii. Adjustment, repair, recementation or replacement of broken tooth for the denture.
   iv. Re-cement or re-bond of an implant or abutment supported crown or fixed partial denture once in any 12-month period
   v. Rebase and reline once in any 3-year period (at least 6 months after the initial installation)
   vi. Tissue conditioning
   vii. Surgical stent in conjunction with a covered surgical procedure

   Other prosthodontic services not mentioned in this section are not covered such as complete or partial interim dentures, precision attachment, provisional or interim pontic, stress breaker, connector bar and coping.

i. Orthodontia
Orthodontia is covered only when medically necessary. The diagnosis and treatment, including placement of a device to facilitate eruption of an impacted tooth, for repair of disabling malocclusion or cleft palate and severe craniofacial defects impacting function of speech, swallowing and chewing are covered. Other orthodontic services not mentioned in this section are not covered.

At the initial placement, the Plan pays 25% of the covered expense for the appliance and the balance will be paid in equal monthly payments over the estimated length of treatment. The Plan's obligation to make payments for treatment will end when treatment stops for any reason prior to completion, or upon termination of eligibility.

Repair of damaged orthodontic appliances, replacement of lost or missing appliance and services to alter vertical dimension and to restore or maintain the occlusion (e.g., equilibration, periodontal splinting, full mouth rehabilitation and restoration for misalignment of teeth) are not covered.

j. Other Services
   i. Palliative treatment of dental pain
   ii. General anesthesia and analgesia
   iii. Therapeutic drug injection

Other services not mentioned in this section are not covered such as behavior management, teledentistry (included in the fees for overall patient management and is not covered as a separate benefit), translation or sign language service (included in the fees for overall patient management and is not covered as a separate benefit) and maxillofacial prosthetics (with the exception of surgical stent mentioned above in section 7.4.7(h)(vi)).

7.4.8 Dental Injury

The Plan covers dental services for treatment of accidental injury to natural teeth. Natural teeth are teeth that grew 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 or chewing food is not an accidental injury)
b. Diagnosis is made within 6 months of the date of injury
c. Treatment must begin within 12 months of the date of injury
d. Treatment is medically necessary and is provided by a physician or dentist while the member is enrolled in the Plan
e. Treatment is limited to that which will restore teeth to a functional state

Implants and implant related services are not covered.

7.4.9 Dental Procedures, Facility Charges

General anesthesia services and related facility charges are covered for a dental procedure performed in a hospital or ambulatory (outpatient) surgical center if medically necessary for members who are:

a. Under age 7
b. Physically or developmentally disabled

c. With a medical condition that would place the member at undue risk if the dental procedure were performed in a dental office

Services must be prior authorized.

7.4.10 Diabetes Services

Insulin and diabetic supplies including insulin syringes, needles and lancets, test strips, glucometers and continuous glucose monitors are covered under the pharmacy benefit (Section 7.8), when purchased from a pharmacy with a valid prescription and using a preferred manufacturer (see the preferred drug list on the Member Dashboard). Insulin pumps may also be covered under the DME benefit (Section 7.7.1).

Covered medical services for diabetes screening and management include:

a. HbA1c lab test
b. Checking for kidney disease
c. Annual dilated eye exam or retinal imaging, including one performed by an optometrist or ophthalmologist
d. Outpatient self management training or education
e. Medical nutrition therapy when prescribed by a professional provider for the treatment of diabetes

7.4.11 Diagnostic Procedures

The Plan covers diagnostic x-rays and laboratory tests related to treatment of a medical condition. Some of these procedures may need to be prior authorized.

All standard imaging procedures related to treatment of a medical condition are covered. Most advanced imaging services must be prior authorized (see section 6.1.1), including radiology (such as MR procedures like MRI and MRA, CT, PET and nuclear medicine) and cardiac imaging.

A full list of diagnostic procedures that must be prior authorized is available on the Moda Health website or by contacting Customer Service.

7.4.12 Electronic Visits

An electronic visit (e-visit) is a structured, secure online consultation between the professional provider and the member. The Plan covers e-visits when the member has previously been treated in the professional provider's office and is established as a patient, and the e-visit is medically necessary for a covered condition.

7.4.13 Gender Confirming Services

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

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

Covered services may include:

a. Mental health
b. Hormone therapy (including puberty suppression therapy for adolescents)
c. Surgical procedures (see section 7.5.10):
    i. Breast/chest surgery

ii. Gonadectomy (hysterectomy/oophorectomy or orchiectomy)
iii. Reconstruction of the genitalia
iv. Gender confirming facial surgery

7.4.14 Health Education Services

Outpatient health education services that manage a covered medical condition (e.g., tobacco cessation programs, diabetes health education, asthma education, pain management, and childbirth and newborn parenting training) are covered at no cost sharing.

7.4.15 Infusion Therapy

Infusion therapy services and supplies are covered when prior authorized and ordered by a professional provider as a part of an infusion therapy regimen. Members may have the option to choose a preferred medication supplier for some medications. Preferred medication suppliers have agreed to the lower contracted rates and may help members save money. See section 7.8.6 for self-administered infusion therapy.

Infusion therapy benefits include the following:

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

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

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

7.4.16 Kidney Dialysis

Covered expenses include:

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

Members with end-stage renal disease (ESRD) must be enrolled in Medicare Part B in order to receive the best benefit.

7.4.17 Massage Therapy

Covered up to an annual visit limit. Massage therapy does not include other services such as manual therapy. They are subject to the Plan's standard benefit for those services. Massage therapy must be prior authorized.

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

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

Members may have the option to choose a preferred medication supplier for some medications. Preferred medication suppliers have agreed to the best contracted rates and may help members save money. Find a preferred provider by contacting Pharmacy Customer Service.

For some medications, members are encouraged to use a preferred treatment center. The treatment program may include office visits, testing, a stay at the treatment center and the medication. Sometimes travel expenses may be included. Treatment must be prior authorized (see section 6.1).

See section 7.4.15 for more information about infusion therapy and prior authorization requirements. Self-administered medications are not covered under this benefit (see section 7.8.6). See section 7.8 for pharmacy benefits.

7.4.19 Mental Health

The Plan covers the following medically necessary services by a mental health provider:

a. Office or home visits, including psychotherapy
b. Intensive outpatient programs
c. Case management, skills training, wrap-around services and crisis intervention
d. Transcranial magnetic stimulation (TMS) and electroconvulsive therapy

Intensive outpatient treatment and TMS require prior authorization. See Section 16 for definitions.

7.4.20 Nutritional Therapy

Outpatient nutritional therapy to manage a covered medical condition is covered. Preventive nutritional therapy that may be required under the Affordable Care Act is covered under the preventive care benefit.

7.4.21 Office or Home Visits

A visit means the member is actually examined by a professional provider. Covered expenses include naturopath office visits, consultations with written reports, and second opinion surgery consultations.

7.4.22 Phenylketonuria

The Plan covers the formulas necessary for the treatment of phenylketonuria.

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

7.4.24 Psychological or Neuropsychological Testing and Evaluation
Covered services include interpretation and report preparation that are necessary to prescribe an appropriate treatment plan.

7.4.25 Rehabilitation and Habilitation & Chronic Pain Care
Rehabilitative and habilitative services provided by a licensed physical, occupational or speech therapist, physician, chiropractor, massage therapist or other professional provider licensed to provide such services, including physical, speech and occupational therapy and cardiac and pulmonary rehabilitation, are subject to annual visit limits except for care for autism spectrum disorders provided. Each session or type of therapy by a different professional provider is counted as one visit except multiple therapy sessions by the same provider in one day are counted as one visit. Limits apply separately to rehabilitative and habilitative services.

Services to treat intractable or chronic pain are subject to the annual limit. Benefits are not provided for both chronic pain care and neurodevelopmental therapy for the same condition.

For members under age 7, or with autism spectrum disorders, neurodevelopmental therapy to restore and improve function and maintenance therapy to prevent significant deterioration in the member's condition or function are covered.

Rehabilitative services are those necessary for restoration of bodily or cognitive functions lost due to a medical condition. Therapy performed to maintain a current level of functioning without documentation of significant improvement is considered maintenance therapy and is not a rehabilitative service.

Habilitative services are those necessary for development of bodily or cognitive functions to perform activities of daily living that never developed or did not develop appropriately based on the member's chronological age. Medically necessary therapy to retain skills necessary for activities of daily living and prevent regression to a previous level of function is a habilitative service. Habilitative services do not include respite care, day habilitation services designed to provide training, structured activities and specialized assistance for adults, chore services to assist with basic needs, educational, vocational, recreational or custodial services.

Rehabilitative and habilitative devices may be limited to those that have FDA approval and are prescribed by a professional provider.

7.4.26 Spinal & Other Manipulations
Covered up to an annual visit limit for treatment of a medical condition. Services such as office visits, lab and diagnostic x-rays and physical therapy services are not covered under this benefit. They are subject to the Plan's standard benefit for those services. Office visits by chiropractors are considered specialist office visits. Spinal manipulation services must be prior authorized as medically necessary.

7.4.27 Substance Use Disorder Services
Services for assessment and treatment of substance use disorder in an outpatient treatment program that meets the definition in the Plan (see Section 16) are covered.

7.4.28 Surgery
Operating rooms and recovery rooms, surgical supplies and other services ordinarily provided by a hospital or surgical center are covered.

Certain surgical procedures are covered only when performed as outpatient surgery. Members should ask their professional provider if this applies to a proposed surgery, or contact Customer Service. See sections 7.5.11 and 7.5.12 for more information about cosmetic and reconstructive surgery.

7.4.29 Therapeutic Injections
Administrative services for therapeutic injections, such as allergy shots, are covered when given in a professional provider's office. When comparable results can be obtained safely with self-administered medications at home, the administrative services for therapeutic injections by the provider are not covered. Vitamin and mineral injections are not covered unless they are medically necessary to treat a specific medical condition. More information is in section 7.4.18 and 7.8.6.

7.4.30 Therapeutic Radiology
Covered expenses include:

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

7.5 Inpatient & Residential Facility Care

Facility care will only be covered when it is medically necessary.

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

Hospitalization must be directed by a physician and must be medically necessary. All inpatient and residential stays require prior authorization (see section 6.1.1). Failure to obtain required prior authorization will result in denial of benefits or a penalty.

Facilities operated by agencies of the federal government are not considered hospitals. However, the Plan will cover expenses incurred in facilities operated by the federal government where benefit payment is required by law.

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

7.5.2 Hospital Benefits

Covered expenses for hospital care are:

a. **Hospital room.** The actual daily charge
b. **Isolation care.** When it is medically necessary, based on generally recognized medical standards, to protect a member from contracting the illness of another person or to protect other patients from contracting the illness of a member
c. **Intensive care unit.** Whether a unit in a particular hospital qualifies as an intensive care unit is determined using generally recognized standards
d. **Facility charges**. For surgery performed in a hospital outpatient department
e. **Other hospital services and supplies**. When medically necessary for treatment and ordinarily furnished by a hospital
f. **Take-home prescription drugs**. Limited to a 3-day supply at the same benefit level as for hospitalization

7.5.3 Hospital Visits

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

7.5.4 Medication Administered at a Preferred Treatment Center

For some medications, members are encouraged to use a preferred treatment center. The treatment program may include office visits, testing, a stay at the treatment center and the medication. Sometimes travel expenses may be included. Treatment must be prior authorized (see section 6.1).

7.5.5 Pre-admission Testing

Medically necessary preadmission testing is covered when ordered by the physician.

7.5.6 Rehabilitative & Chronic Pain Care

To be a covered expense, rehabilitative services must begin within 24 months of the onset of the condition from which the need for services arises and must be a medically necessary part of a physician's formal written program to improve and restore lost function as a result of a medical condition.

Covered rehabilitative care expenses for inpatient services delivered in a hospital or other inpatient facility that specializes in such care are subject to an annual limit, except for treatment of autism spectrum disorders .

Services to treat intractable or chronic pain are subject to the annual limit. Benefits are not provided for both chronic pain care and neurodevelopmental therapy for the same condition.

For members under age 7, or with autism spectrum disorders, neurodevelopmental therapy to restore and improve function and maintenance therapy to prevent significant deterioration in the member’s condition or function are covered.

7.5.7 Residential Mental Health & Substance Use Disorder Treatment Programs

Room and treatment services, including partial hospitalization, by a treatment program that meets the definition in the Plan (see Section 16) are covered.

7.5.8 Skilled Nursing Facility Care

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

Covered skilled nursing facility days are subject to an annual limit as shown in Section 3. Covered expenses are limited to the daily service rate, but no more than the amount that would be charged if the member were in a semi-private hospital room.

Exclusions

The following skilled nursing facility charges are not covered:

a. If the member was admitted before they were enrolled in the Plan
b. If the care is mainly for:
    i. Cognitive decline
    ii. Dementia, including Alzheimer's disease
c. Routine nursing care
d. Non-medical self-help or training
e. Personal hygiene or custodial care

7.5.9 Substance Use Disorder Detoxification Program

Room and treatment services by a state-licensed treatment program are covered.

7.5.10 Surgery

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

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

The maximum plan allowance (MPA) for an assistant surgeon is 20% of the physician’s MPA (or 10% of the PA’s or CRNA’s MPA) as primary surgeon.

Eligible surgery performed in a physician’s office is covered, subject to the appropriate prior authorization.

7.5.11 Surgery, Cosmetic & Reconstructive

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

Cosmetic surgery is not covered. All reconstructive procedures, including surgical repair of congenital deformities, must be medically necessary and prior authorized or benefits will not be paid. Reconstructive procedures that are partially cosmetic in nature may be covered if the procedure is determined to be medically necessary.

Treatment for complications related to a surgery performed to correct a functional disorder is covered when medically necessary. Treatment for complications related to a surgery that does not correct a functional disorder is not covered.

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 7.5.12.

7.5.12 Surgery, Reconstructive Following a Mastectomy

The Plan covers reconstructive surgery following a medically necessary mastectomy (Women's Health and Cancer Rights Act of 1998):

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

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

7.5.13 Transplants

The Plan covers medically necessary transplant procedures that conform to accepted medical practice and are not experimental or investigational.

Definitions

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

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. It includes any other necessary charges directly related to locating and procuring the organ.

Transplant means a procedure or series of procedures by which:

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

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

Covered Benefits. Benefits for transplants are limited as follows:

i. Transplant procedures must be performed at a Center of Excellence. If a Center of Excellence cannot provide the necessary type of transplant, Moda Health will prior authorize services at an alternative transplant facility
ii. Donor costs are covered as follows:
    A. If the recipient or self-donor is enrolled in the Plan, donor costs related to a covered transplant are covered
    B. If the donor is enrolled in the Plan and the recipient is not, the Plan will not pay any benefits toward donor costs
    C. If the donor is not enrolled in the Plan, expenses that result from complications and unforeseen effects of the donation are not covered
    D. Donor costs paid under any other health coverage are not covered by the Plan.
iii. Travel and housing expenses for the recipient and one caregiver, or 2 caregivers if the recipient is a minor, are covered up to a maximum per transplant when the recipient resides more than 50 miles from the Center of Excellence unless the medical condition requires treatment at a closer transplant facility.
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 benefit (section 7.8)
vi. The Plan will not pay for chemotherapy with autologous or homogenic/allogenic bone marrow transplant for treatment of any type of cancer not approved for coverage

7.6 MATERNITY CARE

Pregnancy care, childbirth and related conditions are covered when rendered by a professional provider.

Maternity services are billed as a global charge. This is a lump sum charge for maternity care that includes prenatal care, labor and delivery, and post-delivery care.

Some diagnostic services, such as amniocentesis and fetal stress test, are not part of global maternity services and are reimbursed separately.

If a member changes providers during pregnancy, maternity services are generally no longer billed as a global charge.

Home birth expenses are not covered other than medically necessary supplies and fees billed by a professional provider. Additional information regarding home birth exclusions is in Section 8. Supportive services, such as physical, emotional and information support to the mother before, during and after birth and during the postpartum period, are not covered expenses.

7.6.1 Abortion

Elective abortions are covered.

7.6.2 Breastfeeding Support

Comprehensive lactation support and counseling is covered during pregnancy and/or the breastfeeding period. The Plan covers the purchase or rental charge (not to exceed the purchase price) for a breast pump. Charges for accessories or supplies such as repair kits, replacement or

extra parts, milk storage bags and extra ice packs, bottles or coolers are not covered. Hospital grade pumps are covered when medically necessary.

7.6.3 Circumcision

Circumcision for a newborn is covered when performed within 3 months of birth and may be performed without prior authorization. A circumcision beyond age 3 months must be medically necessary and requires prior authorization.

7.6.4 Diagnostic Procedures

The Plan covers diagnostic services, including laboratory tests and ultrasounds, related to maternity care.

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

7.6.5 Office, Home or Hospital Visits

A visit means the member is actually examined by a professional provider.

7.6.6 Hospital Benefits

Covered hospital maternity care expenses consist of the following:

a. **Hospital room.** The actual daily charge
b. **Facility charges**. When provided at a covered facility, including a birthing center
c. **Other hospital services and supplies**. When medically necessary for treatment and ordinarily furnished by a hospital
d. **Nursery care.** While the member is confined in the hospital and receiving maternity benefits. The deductible is waived for routine nursery care. Includes one in-nursery well-newborn infant preventive health exam covered at no cost sharing when performed in-network. Additional visits are covered at the hospital visit benefit level.
e. **Take-home prescription drugs**. Limited to a 3-day supply at the same benefit level as for hospitalization.

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

7.7 Other Services

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

7.7.1 Durable Medical Equipment (DME), Supplies & Appliances

Equipment and related supplies, including sales tax, that help members manage a medical condition. DME is typically for home use and is designed to withstand repeated use.

Some examples of DME, supplies and appliances are:

a. CPAP for sleep apnea
b. Glasses or contact lenses for the diagnosis of aphakia or keratoconus
c. Medical vision hardware for treatment of corneal ulcer, bullous keratopathy, recurrent erosion of cornea, tear film insufficiency, aphakia, Sjogren's disease, congenital cataract, corneal abrasion and keratoconus.
d. Insulin pumps
e. Hospital beds and accessories
f. Intraocular lens within 90 days of cataract surgery
g. Light boxes or light wands only when treatment is not available at a provider's office
h. Orthotics, orthopedic braces, orthopedic shoes to restore or maintain the ability to complete activities of daily living or essential job-related activities. If needed correction or support is accomplished by modifying a mass-produced shoe, then the covered expense is limited to the cost of the modification. Orthotics or orthopedic shoes are covered when medically necessary.
i. Oxygen and oxygen supplies
j. Prosthetics
k. Wheelchair or scooter (including maintenance expenses)

Diabetic supplies, other than insulin pumps and related supplies, are only covered when purchased from a pharmacy with a valid prescription and using a preferred manufacturer (see section 7.8 for coverage under Pharmacy benefit.)

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

Members may contact Customer Service for help finding an in-network DME provider.

Moda Health encourages the use of a preferred DME provider. Using a preferred DME provider may help members save money. Find a preferred provider using Find Care on the Member Dashboard (see section 5.2.2). A member can change a recurring prescription or automated billing to a preferred DME provider by contacting their current provider and the preferred DME provider to request the change.

All supplies, appliances and DME must be medically necessary. Some require prior authorization (see section 6.1.1). A full list of medical equipment requiring prior authorization is available on the Moda Health website or by contacting Customer Service. Replacement or repair is only covered if the appliance, prosthetic, equipment or DME was not abused, was not used beyond its specifications and not used in a manner to void applicable warranties. Upon request, members must authorize any supplier furnishing DME to provide information related to the equipment order and any other records Moda Health requires to approve a claim payment.

Exclusions
In addition to the exclusions listed in Section 8, the Plan will not cover the following appliances and equipment, even if they relate to a condition that is otherwise covered by the Plan:

a. Those used primarily for comfort, convenience, or cosmetic purposes
b. Wigs and toupees
c. Those used for education or environmental control (examples of Supportive Environmental materials can be found in Section 8)
d. Dental appliances and braces
e. Therapeutic devices, except for transcutaneous nerve stimulators

f. Incontinence supplies
g. Supporting devices such as corsets, compression or therapeutic stockings except when such stockings are medically necessary
h. Testicular prostheses
i. Hearing aids, eye glasses and contact lenses except as otherwise covered under the Plan

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

7.7.2 Home Healthcare

Home healthcare services and supplies are covered when provided by a home healthcare agency for a member who is homebound. Homebound means that the member's condition creates a general inability to leave home. If the member does leave home, the absences must be infrequent, of short duration, and mainly for receiving medical treatment. A home healthcare agency is a licensed public or private agency that specializes in providing skilled nursing and other therapeutic services, such as physical therapy, in the member's home.

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

a. Registered or licensed practical nurse
b. Physical, occupational, speech, or respiratory therapist
c. Licensed social worker

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

This benefit does not include home healthcare, home care services, and supplies provided as part of a hospice treatment plan. These are covered under sections 7.7.1 and section 7.7.3.

Home health visits are subject to an annual limit for the services of a registered or licensed practical nurse. All other types of home healthcare providers are limited to one visit per day.

7.7.3 Hospice Care

Definitions

Hospice means a private or public hospice agency or organization approved by Medicare or licensed or certified by the state it operates in.

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

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

The Plan covers the services and supplies listed below when included in a hospice treatment plan. Services must be for intermittent medically necessary or palliative care provided by a hospice agency to a member who is terminally ill and not seeking further curative treatment.

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

i. Registered or licensed practical nurse
ii. Physical, occupational or speech therapist
iii. Certified respiratory therapist
iv. Home health aide
v. Licensed social worker

Hospice Inpatient Care
The Plan covers short-term hospice inpatient services and supplies for a limited number of days.

Respite Care
The Plan covers respite care (as defined in Section 16) provided to a member who requires continuous assistance when arranged by the attending professional provider and prior authorized. Benefits are limited to an hourly maximum for services provided in the most appropriate setting. The services and charges of a non-professional provider may be covered for respite care if Moda Health approves in advance.

Exclusions
In addition to exclusions listed in Section 8, the following are not covered:

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

7.7.4 Medical Travel Support
The Plan covers some surgical procedures at the cost share in Section 3 when they are provided at a preferred facility, which may include:

Through SurgeryCare:
- orthopedic
- cardiac
- vascular
- general surgery
- spine
- neurologic
- women's health

Through OHSU:
- knee
- shoulder
- foot and ankle

Members who have upcoming medical procedures can call Moda Health at 800-592-8283 to start the process. A Care Coordinator will review the proposed procedures and determine if it is eligible to get care in a preferred facility. Once eligibility is established, members can select a preferred provider and facility. The Care Coordinator will then coordinate with members' providers in both locations to set up the treatment plan.

The Plan also covers coach airfare, ground transportation and lodging necessary for the member and one companion for traveling to get care. Members eligible for care in a preferred facility can contact the Care Coordinator to arrange for transportation and lodging. Transportation and lodging costs will be reimbursed at the current IRS travel mileage and lodging guidelines on the date the expenses were incurred. For medical travel, if members follow the travel arrangement made by the Plan, the Plan covers the travel expenses and there is no cost on the members. Medical travel support coverage does not include any additional expenses such as food or toiletry.

If medical travel support was approved, scheduled and paid by the Plan but members decided not to proceed with the medical procedure for reasons other than medical necessity, members are responsible for the entire cost of the unused airfare, ground transportation and lodging expenses.

7.7.5 Nonprescription Enteral Formula for Home Use

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

7.7.6 Virtual Care Visits (Telehealth Services)

Virtual care, also known as telehealth, is a live, interactive audio, visual or data communication visit (such as telephone or email) with a provider. It generally includes diagnosis and treatment of chronic or minor medical conditions. Medical information is communicated in real time between the member at one location (such as a doctor's office or home) and a provider at another location.

Covered services, when generally accepted healthcare practices and standards determine they can be safely and effectively provided using virtual care, are covered when provided by a provider licensed in Alaska using such methods as long as the application and technology used meet all state and federal standards for privacy and security of protected health information, unless the requirement is exempt during a state emergency.

Virtual care visits through CirrusMD at modahealth.com/cirrusmd are covered at no cost sharing.

7.8 PHARMACY PRESCRIPTION BENEFIT

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

7.8.1 Definitions

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

Brand Substitution is a policy on how prescription medications are filled at the pharmacy. Both generic and brand medications are covered. If a member requests, or the treating professional provider prescribes, a brand medication when a generic equivalent is available, the member may be responsible for the nonpreferred cost sharing plus the difference in cost between the generic and brand medication.

Formulary is a list of all prescription medications and their coverage under the pharmacy prescription benefit. A prescription price check tool is available on the Member Dashboard under the pharmacy tab. This online formulary tool provides coverage information, treatment options and price estimates.

Generic Medications are medications that have been found by the Food and Drug Administration (FDA) to be therapeutically equivalent to the brand alternative and are often the most cost effective option. Generic medications must contain the same active ingredients as their brand counterpart and be identical in strength, dosage form and route of administration.

Nonpreferred Tier Medications means brand medications, including specialty brand medications, that have been reviewed by Moda Health and do not have significant therapeutic advantage over their preferred alternative. These products generally have safe and effective options available under the Value, Select and/or Preferred tiers.

Over the Counter (OTC) Medications are medications that may be purchased without a professional provider's prescription. Moda Health follows the federal designation of OTC medications to decide if an OTC medication is covered by the Plan.

Preferred Tier Medications means those medications, including specialty preferred medication, that have been reviewed by Moda Health and found to be safe and clinically effective at a favorable cost when compared to other medications in the same therapeutic class and/or category. Generic medications may be included in this tier when they have not been shown to be safer or more effective than other more cost effective generic medications.

Prescription Medication List means the Moda Health Prescription Medication List. The list is available on the Member Dashboard. It provides information about the coverage of commonly prescribed medications. It is not an all-inclusive list of covered products. Medications that are new to the market are subject to review and may have additional coverage limitations established by Moda Health.

The prescription medication list and the tiering of medications may change and will be periodically updated. A prescription price check tool is available on the Member Dashboard under the pharmacy tab. Members with any questions regarding coverage should contact Customer Service.

Moda Health is not responsible for any prescribing or dispensing decisions. These decisions are to be made by the professional provider and pharmacist using their professional judgment. Members should talk with their professional providers about whether a medication from the list is appropriate for them. This list is not meant to replace a professional provider's judgment when making prescribing decisions.

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

Select Tier Medications include those generic medications that are safe and effective, and represent the most cost effective option within their therapeutic category. Certain brand medications that are both clinically favorable and cost effective are also included.

Self-Administered Medications are labeled by the FDA for self-administration. They can be safely administered by the member or the member's caregiver outside of a medically supervised setting (such as a physician's office, infusion center or hospital). These medications do not usually require a licensed medical provider to administer them.

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

Value Tier Medications are medications that include commonly prescribed products used to treat chronic medical conditions, and that are considered safe, effective and cost-effective to alternative medications. A list of value tier medications is available on the Member Dashboard.

7.8.2 Covered Expenses

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

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

A covered expense must be medically necessary, defined as delivery of a service by a qualified healthcare provider, exercising prudent clinical judgement, that meets all of the following:

a. Is for the purpose of preventing, evaluating, diagnosing or treating a medical condition or its symptoms
b. Meets generally accepted standards of medical practice
c. Is proven to produce intended effects on health outcomes (e.g., morbidity, mortality, quality of life, symptom control, function) associated with the member's medical condition or its symptoms
d. Has beneficial effects on health outcomes that outweigh the potential harmful effects
e. Is clinically appropriate in terms of type, frequency, extent, site and duration
f. Is not primarily for the convenience of the patient or healthcare provider
g. Is at least as likely to produce equivalent therapeutic or diagnostic results for the diagnosis or treatment of the member's medical condition or its symptoms as an alternative service or therapy, including no intervention, and is not more costly than an alternative service or sequence of services

For these purposes, "generally accepted standards of medical practice" are standards based on reliable scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations, and the views of physicians practicing in relevant clinical areas, and other relevant factors. For new treatments, effectiveness is determined by reliable scientific evidence that is published in peer-reviewed medical literature. For existing treatments, effectiveness is determined first by scientific evidence, then by professional standards, then by expert opinion. The fact that medications are FDA-approved and were furnished, prescribed or approved by a physician or other qualified provider does not in itself mean that they are medically necessary.

7.8.3 Covered Medication Supply

Includes the following:

a. A prescription medication that is medically necessary for treatment of a medical condition
b. Compounded medications containing at least one covered medication as the main ingredient
c. Insulin and diabetic supplies including insulin syringes, needles and lancets, test strips, glucometers and continuous glucose monitors. Must have a valid prescription and use a preferred manufacturer

d. Medications for treating tobacco dependence, including OTC nicotine patches, gum or lozenges, with a valid prescription and from an in-network retail pharmacy, are covered with no cost sharing as required under the Affordable Care Act
e. Certain prescribed preventive medications required under the Affordable Care Act
f. Prescription contraceptive medications and devices for birth control (section 7.3.2) and medical conditions covered under the Plan.
g. Certain immunizations (section 7.3.3) and related administration fees are covered with no cost sharing at in-network retail pharmacies (e.g., flu, pneumonia and shingles vaccines)
h. Inhalation spacer devices and peak flow meters
i. One early refill for a covered topical eye medication to treat a chronic condition during the approved dosage period if the refill does not exceed the number of refills prescribed and if the request is not made earlier than 23 days after a 30-day supply is dispensed, 45 days after a 60-day supply is dispensed or 68 days after a 90-day supply is dispensed.

Certain prescription medications and/or quantities of prescription medications may require prior authorization (see section 6.1.1). Specialty tier and some other tier medications must be dispensed through a Moda-designated specialty pharmacy provider. For assistance coordinating prescription refills, contact Customer Service.

7.8.4 Mail Order Pharmacy

Members can choose to fill prescriptions for covered medications through a Moda-designated mail order pharmacy. A mail order pharmacy form can be obtained from the Group, on the Member Dashboard or by contacting Customer Service.

7.8.5 Specialty Services & Pharmacy

Specialty medications are often used to treat complex chronic health conditions. The member's pharmacist and other professional providers will tell a member if a prescription requires prior authorization or must be obtained from a Moda-designated specialty pharmacy. Information about the clinical services and a list of covered specialty medications is available on the Member Dashboard or by contacting Customer Service.

Most specialty medications must be prior authorized. If a member does not purchase specialty medications at the Moda-designated specialty pharmacy, the expense will not be covered. In the event a specialty medication is not available when needed and a delay in receiving the medication would threaten the efficacy of treatment or the life of the member, Moda Health will prior authorize the medication to be filled locally. For assistance, contact Customer Service.

Some specialty prescriptions may have shorter day supply coverage limits. Some medications may be eligible for a 90-day supply. For some specialty medications, members may be required to enroll in programs to ensure proper medication use and/or reduce the cost of the medication. More information is available on the Member Dashboard or by contacting Customer Service.

7.8.6 Self-Administered Medication

All self-administered medications are subject to the prescription medication requirements of section 7.8. Self-administered specialty medications are subject to the same requirements as other specialty medications (section 7.8.5).

Self-administered injectable medications are not covered when supplied in a provider's office, clinic or facility.

7.8.7 Step Therapy

When a medication is part of the step therapy program, members must try certain medications (Step 1) before the prescribed Step 2 medication will be covered. When a prescription for a step therapy medication is submitted out of order, meaning the member has not first tried the Step 1 medication before submitting a prescription for a Step 2 medication, the prescription will not be covered. When this happens, the provider will need to prescribe the Step 1 medication. For assistance with step therapy exceptions, contact Customer Service.

7.8.8 Limitations

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

a. New FDA approved medications are subject to review and may have additional coverage requirements or limits set by the Plan. A member or prescriber can request a medical necessity evaluation if a newly approved medication is initially denied during the review period.
b. If a brand medication is filled by the pharmacy when a generic equivalent is available, the member may have to pay the difference in cost between the generic and brand medication. Expenses incurred due to brand substitution do not count toward the out-of-pocket maximum
c. Certain brand medications may be prior authorized for a specific amount of time or until a generic medication becomes available, whichever comes first. When a generic medication becomes available during the authorized period, the brand medication is no longer covered. The member can get the generic medication without a new prescription or authorization.
d. Starting treatment with a medication, whether by using free samples or otherwise, does not bypass the Plan's requirements (e.g., step therapy, prior authorization) before Plan benefits are available.
e. Some specialty medications that have been found to have a high discontinuation rate or short duration of use may be limited to a 15-day supply.
f. Medications with dosing intervals greater than the Plan's maximum day supply will have an increased copayment to match the day supply.
g. Medications purchased outside of the United States and its territories are only covered in emergency and urgent care situations.
h. Early refill of medications for travel outside of the United States will be reviewed. When allowed, early refill is limited to once every 6 months. Early refill cannot be used to cover a medication supply beyond the end of the plan year.

7.8.9 Exclusions

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

a. **Devices.** Including, but not limited to therapeutic devices and appliances. Information for contraceptive devices is in section 7.3.2 and for other devices in section 7.8.3
b. **Foreign Medication Claims.** Medications purchased from non-U.S. mail order or online pharmacies or U.S. mail or online pharmacies acting as agents of non-U.S. pharmacies.
c. **Hair Growth Medications.**
d. **Immunization Agents for Travel.** Except as required under the Affordable Care Act.
e. **Institutional Medications.** To be taken by or administered to a member while they are a patient in a hospital, rest home, skilled nursing facility, extended care facility, nursing home, or similar institution.

f. **Medication Administration.** A charge for administration or injection of a medication, except for certain immunizations at in-network retail pharmacies
g. **Medications Covered Under Another Benefit**. Such as medications covered under hospice, home health, medical, etc.
h. **Medications Not Approved by FDA.** Products not recognized or designated as FDA approved medications. This includes medications that are found to be less than effective by the FDA's Drug Efficacy Study Implementation (DESI) classifications.
i. **Non-Covered Condition.** A medication prescribed for reasons other than to treat a covered medical condition
j. **Nutritional Supplements and Medical Foods.**
k. **Off-label Use.** Medications prescribed for or used for non-FDA approved indications, unless confirmed by other research studies, reference, compendium, or the federal government.
l. **Over the Counter (OTC) Medications** and certain prescription medications for which there is an OTC equivalent or alternative (see the preferred drug list on the Member Dashboard), except for those treating tobacco dependence.
m. **Repackaged Medications.**
n. **Replacement Medications and/or Supplies.**
o. **Vitamins and Minerals.** Except as required by law.
p. **Weight Loss Medications.**

7.9 VISION CARE BENEFIT

7.9.1 Pediatric Vision Services

The Plan covers the following services every year for members through the end of the month in which they reach age 19:

a. one complete well-vision exam
b. one pair of eyeglasses and frames, or contact lenses instead of eyeglasses
    i. eyeglass lenses may be
        A. polycarbonate, plastic or glass
        B. single vision, lined bifocal, lined trifocal or lenticular
    ii. Contact lenses require a minimum 3-month supply
        A. standard (one pair per year)
        B. monthly (6-month supply)
        C. bi-weekly (3-month supply)
        D. daily (3-month supply)
c. Optional lenses and treatments limited to:
    i. ultraviolet protective coating, anti-reflective (AR) coating, polarized lenses,
    ii. blended segment lenses, intermediate vision lenses, progressive lenses
    iii. photochromic glass lenses, plastic photosensitive lenses
    iv. hi-index lenses

Members can visit www.vsp.com or call 800-877-7195 to choose an in-network vision care provider and arrange for vision services. Some vision services may require prior authorization.

For members who are eligible for vision plan benefits, VSP will provide benefit authorization directly to the in-network doctor. When contacting an in-network doctor directly, members must identify themselves as VSP members so the doctor will obtain benefit authorization from VSP. Should members receive services from an in-network doctor without such benefit authorization or obtain services from a provider who is not an in-network doctor, they are responsible for

payment in full to the provider and will need to submit a request for reimbursement by completing the member reimbursement claim form, which is available by visiting www.vsp.com or calling 800-877-7195. Payment in these instances is limited to those for an out-of-network provider.

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

a. Plano lenses with refractive correction of less than ± 50 diopter
b. Two pairs of glasses instead of bifocals
c. Insurance policies or services agreements for contact lens coverage
d. Artistically painted or non-prescription contact lenses
e. Additional office visits for contact lens pathology
f. Contact lens modification, polishing or cleaning

7.9.2 Adult Vision Services

The Plan pays for vision examinations and corrective lenses and frames for members age 19 and older. Members can visit www.vsp.com or call 800-877-7195 to choose an in-network vision care provider and arrange for vision services. Some vision services may require prior authorization.

For members who are eligible for vision plan benefits, VSP will provide benefit authorization directly to the in-network doctor. When contacting an in-network doctor directly, members must identify themselves as VSP members so the doctor will obtain benefit authorization from VSP. Should members receive services from an in-network doctor without such benefit authorization or obtain services from a provider who is not an in-network doctor, they are responsible for payment in full to the provider and will need to submit a request for reimbursement by completing the member reimbursement claim form, which is available by visiting www.vsp.com or calling 800-877-7195. Payment in these instances is limited to those for an out-of-network provider.

The following services and supplies are covered up to the limits and maximums described in Section 3:

a. One complete eye exam annually, including the charge for refraction
b. One pair of frames for corrective lenses are covered every 2 years
c. One pair of corrective lenses annually, including lens enhancement. Elective contact lenses in lieu of eyeglasses are covered annually
d. Low vision testing and aids every 2 years for members who have severe visual problems that are not correctable with regular lenses

Whether under the vision care benefit or the medical portion of the Plan, benefits are limited to one pair of contact lenses, disposable contacts, or lenses for eyeglasses per year and one set of frames every 2 years.

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

a. Plano lenses with refractive correction of less than ± 50 diopter
b. Two pairs of glasses instead of bifocals
c. Insurance policies or services agreements for contact lens coverage
d. Artistically painted or non-prescription contact lenses
e. Additional office visits for contact lens pathology
f. Contact lens modification, polishing or cleaning

7.10 HEARING SERVICES BENEFIT

The Plan covers ear and hearing examinations, testing and hearing hardware. Hearing aids are limited to a dollar maximum in a 3-year period, beginning with the date of the otological (ear) examination. Members must be examined by a licensed physician before obtaining a hearing aid. To qualify for this benefit, members must purchase a hearing aid device. The Plan covers one otological (ear) exam by a physician or surgeon every 2 years. The following expenses are covered once in a 3-year period:

a. One audiological (hearing) exam and evaluation by a certified or licensed audiologist or hearing aid specialist, including a follow-up consultation
b. A hearing aid (monaural or binaural) prescribed as a result of the examination
c. Ear molds
d. Hearing aid instruments
e. Initial batteries, cords and other necessary supplementary equipment
f. Warranty
g. Follow-up consultation within 30 days following delivery of the hearing aid
h. Repairs, servicing or alteration of the hearing aid equipment

To get the highest benefit level for a hearing aid, members can call 866-202-2178 to choose an in-network audiologist and arrange for a hearing exam. The audiologist will assist members with choices of hearing aids through an in-network hearing instrument provider. The hearing services vendor has a selection of hearing aids available to Plan members.

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

a. Replacement of a hearing aid, for any reason, more than once in a 3-year period
b. Batteries or other supplementary equipment other than those obtained upon purchase of the hearing aid
c. A hearing aid exceeding the specifications prescribed for correction of hearing loss

SECTION 8. GENERAL EXCLUSIONS

In addition to the limitations and exclusions described elsewhere in the Plan, the following services, supplies (including medications), procedures and conditions are not covered, even if otherwise medically necessary, if they relate to a condition that is otherwise covered by the Plan, or if recommended, referred, or provided by a provider. Any direct complication or consequence that arises from these exclusions will not be covered.

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

Care Outside the United States
Scheduled care or care that is not due to an urgent or emergency medical condition

Charges Over the Maximum Plan Allowance

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

Cosmetic Procedures
Any procedure or medication requested for the purpose of improving or changing appearance without restoring impaired body function, including rhinoplasty, breast augmentation, lipectomy, liposuction, and hair removal (including electrolysis and laser). Exceptions are provided for reconstructive surgery if medically necessary and not specifically excluded (e.g., mastectomy, section 7.5.12)

Court Ordered Services
Including services related to deferred prosecution, deferred or suspended sentencing or to driving rights, except when medically necessary

Custodial Care
Routine care and hospitalization that helps a member with activities of daily living, such as bathing, dressing, getting in and out of bed, preparation of special diets, and supervision of medication that usually can be self-administered. Custodial care is care that can be provided by people without medical or paramedical skills.

Dental Examinations and Treatment; Orthodontia
Except as specifically provided for in sections 7.4.7 and 7.4.8

Educational Supplies
Including books, tapes, pamphlets, subscriptions, videos and computer programs (software)

Enrichment Programs
Psychological or lifestyle enrichment programs including self-help programs, educational programs, assertiveness training, marathon group therapy, and sensitivity training, except as covered under section 7.4.14

Equine Therapy

Experimental or Investigational Procedures and Medications
Including expenses incidental to or incurred as a direct consequence of such procedures or medications (see definition of experimental/investigational in Section 16)

Faith Healing

Financial Counseling Services

Food Services
Meals on Wheels and similar programs

Guest Meals in a Hospital or Skilled Nursing Facility

Hearing Aids
Including implantable hearing aids and the surgical procedure to implant them

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

Homeopathic Treatment and Supplies

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

Infertility
All services and supplies for office visits, diagnosis and treatment of infertility, as well as the cause of infertility. Includes surgery to reverse elective sterilization (vasectomy or tubal ligation)

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

Intellectual Disability/Learning Disorders
Treatment related to intellectual disability and learning disorders, and services or supplies provided by an institution for the intellectually disabled

Legal Counseling

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 a mental health condition

Missed Appointments

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

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

Nutritional Therapy
Except as provided for in section 7.4.20

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 medication or formula related to or resulting from the treatment of weight loss or obesity even if prescribed by a physician

The Plan covers services and supplies that are necessary 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
Except as provided in section 7.7.1

Orthognathic Surgery
Including associated services and supplies

Pastoral and Spiritual Counseling

Personality Disorders

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

Physical Exercise Programs

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 claim forms or treatment plans

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

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

Self-Administered Medications
Including oral and self injectable, when provided directly by a physician's office, facility or clinic instead of through the pharmacy prescription medication or anticancer benefits (sections 7.8.6 and 7.4.2)

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

Services Not Provided

Services Otherwise Available
Including those services or supplies:

a. for which payment could be obtained in whole or in part if a member had applied for payment under any city, county, state, or federal law, except for Medicaid coverage
b. for which a member cannot be held liable because of an agreement between the provider and another third party payer that has paid or is obligated to pay for such service or supply
c. for which no charge is made (including reducing a charge due to a coupon or manufacturer discount), or for which no charge is normally made in the absence of insurance
d. provided under separate contracts that are used to provide coordinated coverage for covered persons in a group and are considered parts of the same plan
e. a member could have received in a hospital or program operated by a government agency or authority. This exclusion does not apply 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 or Ordered by a Relative
Other than services by a dental provider. Relatives, for the purpose of this exclusion, include a member or a spouse or domestic partner, child, sibling, or parent of a member or their spouse or domestic partner

Services Provided by Volunteer Workers

Sexual Dysfunction and Paraphilic Disorders
Services or supplies for treatment of sexual dysfunction or paraphilia. In addition, court-ordered sex offender treatment is not covered.

Support Education
Including:

a. Level 0.5 education-only programs
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
Including hand rails, ramps, bath benches, humidifiers, air filters, air conditioners, heat lamps, tanning lights, whirlpools, hot tubs, and telephones, and other items that are not for 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

Taxes
Except sales tax related to durable medical equipment, appliances and supplies

Telehealth
Including Telemedicine, telephone visits or consultations and telephone psychotherapy, except for electronic visits covered in section 7.4.12 and virtual care visits (telehealth) covered in section 7.7.6

Telephones and Televisions in a Hospital or Skilled Nursing Facility

Temporomandibular Joint Syndrome (TMJ)
Services and supplies related to the treatment of TMJ

Third Party Liability Claims
Services and supplies for treatment of a medical condition for which a third party is or may be responsible, to the extent of any recovery received from or on behalf of the third party (see section 11.4.2)

Transportation
Except medically necessary ambulance transport, commercial transportation, travel for transplant treatment, covered transportation for clinical trials and travel under medical travel support

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 persons in the absence of illness or a diagnosed mental health or substance use disorder condition, or treatment of normal transitional response to stress

Treatment After Coverage Ends
The only exception is if a member is hospitalized at the time the Plan ends (see section 7.1), or for covered hearing aids, if the prescription is written and the hearing aid is ordered during the 30 days before coverage ends and received within 30 days of the end date

Treatment Before Coverage Begins

Treatment Not Medically Necessary
Including services, supplies or medications that are:

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

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

Vision Care
Except as otherwise provided under the Plan. This includes any charges for orthoptics or vision training and any associated supplemental testing, vitamin therapy, low vision therapy, eye exercises or fundus photography. See section 7.4.10 for coverage of annual dilated eye exam for management of diabetes

Vision Surgery
Any procedure to cure or reduce myopia, hyperopia, or astigmatism, including reversal or revisions of any such procedures and any complications of these procedures

Vitamins and Minerals
Except as required by law. Otherwise, not covered unless medically necessary for treatment of a specific medical condition and only under the medical benefit and if they require a prescription and a dosage form of equal or greater strength of the medication is not available without a prescription under federal law. This applies whether the vitamin or mineral is oral, injectable, or transdermal. Naturopathic substances are not covered.

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 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 the Group does not provide workers' compensation coverage to them.

SECTION 9. ELIGIBILITY

The date a person becomes eligible may be different than the date coverage begins (see section 10.5).

9.1 SUBSCRIBER

A person is eligible to enroll in the Plan if they:

a. are a permanent documented employee. An eligible employee includes sole proprietors, partners of a partnership, or an independent contractor if the sole proprietor, partner, or contractor is included as an employee under the Plan
b. work on a regularly scheduled basis the specified hours per week as required by the Group
c. are not a leased, seasonal, substitute, or temporary employee, or an agent or consultant
d. are paid on a regular basis through the payroll system, and have federal taxes deducted from such pay, and are reported to Social Security (a sole proprietor, business partner, or independent contractor may be considered an eligible employee if they have federal taxes deducted from any income related to the Group's business)
e. satisfy any cumulative hours of service requirement and orientation and/or eligibility waiting period

Coverage is available to all eligible employees and their dependents to the extent the Group chooses to provide coverage.

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

9.2 DEPENDENTS

A subscriber's legal spouse is eligible for coverage. However, if the subscriber and the spouse are legally separated, the spouse is not eligible unless they meet the requirements to enroll as an employee. A subscriber's children are eligible until their 26th birthday. Children eligible due to a court or administrative order are subject to the Plan's child age limit.

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

a. The biological or adopted child of a subscriber or a subscriber's eligible spouse
b. Children placed for adoption with a subscriber. Adoption paperwork must be provided
c. A newborn child of an enrolled dependent
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

A subscriber's child who has sustained a disability making them physically or mentally incapable of self-support at even a sedentary level may be eligible for coverage even though they are over 26 years old. To be eligible, the child must be unmarried and principally dependent on the subscriber for support and have had continuous medical coverage. The incapacity must have started, and the information below must be received, before the child's 26th birthday. Social Security Disability status does not guarantee coverage under this provision. Moda Health will

determine eligibility based on commonly accepted guidelines. To avoid a break in coverage, it is recommended that the following information be submitted to Moda Health at least 45 days before the child's 26th birthday:

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

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

9.3 QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

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

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

9.4 NEW DEPENDENTS

A new dependent may cause a premium increase. Premiums will be adjusted accordingly and will apply from the date coverage is effective.

If a subscriber marries, the spouse and their children are eligible to enroll as of the date of the marriage.

A member's newborn child is eligible from birth. A subscriber's adopted child, or child placed for adoption, will be eligible on the date of placement. To enroll a new child, an application must be submitted. When a premium increase is required, the application and payment must be submitted within 31 days. If payment is required but not received, coverage for the child will end 31 days following birth or adoption. Proof of legal guardianship is required to cover a grandchild beyond the first 31 days from birth if their parent is not an enrolled dependent under the Plan.

9.5 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, and any other evidence necessary to document eligibility on the Plan.

SECTION 10. ENROLLMENT

10.1 ENROLLING ELIGIBLE EMPLOYEES

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

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

10.2 ENROLLING NEW DEPENDENTS

To enroll a new dependent, a complete and signed application and, when applicable, a marriage certificate, or adoption or placement for adoption paperwork must be submitted within 31 days of their eligibility. The subscriber must notify Moda Health if family members are added or dropped from coverage, even if it does not affect premiums.

10.3 OPEN ENROLLMENT

If an eligible employee and/or any eligible dependents are not enrolled within 31 days of first becoming eligible, they must wait for the next open enrollment period to enroll unless:

a. The person qualifies for special enrollment as described in section 10.4
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 the court order is issued
c. The person's coverage under Medicaid, Medicare, Tricare, Indian Health Service or a publicly sponsored or subsidized health plan has been involuntarily terminated within 90 days prior to applying for coverage in a group health benefit plan.

Open enrollment occurs once a year at renewal.

10.4 SPECIAL ENROLLMENT RIGHTS

The special enrollment rights described in sections 10.4.1 and 10.4.2 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 other coverage or becomes eligible for a premium assistance subsidy
c. To both the eligible employee and their dependent if neither is enrolled under the Plan and either loses other coverage or becomes eligible for a premium assistance subsidy

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

10.4.1 Loss of Other Coverage

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

a. They were covered under a group health plan or had health insurance coverage at the time coverage was previously offered
b. They stated in writing at such time that coverage under a group health plan or health insurance coverage was the reason enrollment was declined
c. They request 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. Their prior coverage was under a COBRA continuation provision and the coverage under such provision was exhausted
    ii. Their prior coverage ended as a result of loss of eligibility for the coverage. Examples of when coverage under a plan may be lost include:
        A. legal separation or divorce
        B. loss of dependent status per plan terms
        C. death
        D. end of employment
        E. reduction in the number of hours of employment
        F. the plan stops offering coverage to a group of similarly situated persons
        G. moving out of an HMO service area that causes coverage to end and no other option is available under the plan
        H. termination of the benefit package option, and no substitute option is offered
    iii. The employer contributions toward their other active (not COBRA) coverage end. (If employer contributions stop, the eligible employee or dependent does not have to end coverage to be eligible for special enrollment on a new plan.)
    iv. Their prior coverage was under Medicaid or a children's health insurance program (CHIP) and such coverage ended due to loss of eligibility. Special enrollment must be requested within 60 days of the end of coverage.

10.4.2 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.

10.4.3 New Dependents

An eligible employee, spouse and children 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, birth, adoption, or placement for adoption) See section 10.2.

10.5 When Coverage Begins

Coverage for subscribers begins on the enrollment date or after a waiting period, as specified in the policy.

Coverage for new dependents through marriage begins on the first day of the month following receipt of the application.

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 that the Group determines that an applicable order qualifies as a QMCSO, and that the child is eligible for enrollment in the Plan.

Coverage for those enrolling during open enrollment begins on the date the Plan renews. All other plan provisions will apply. Coverage under special enrollment due to loss of coverage or eligibility for premium subsidy begins on the first day of the month following receipt of the special enrollment request, or coinciding with, but not before the loss of other coverage.

The necessary premiums must also be paid for coverage to become effective.

10.6 WHEN COVERAGE ENDS

When the subscriber's coverage ends, coverage for all enrolled dependents also ends.

10.6.1 Group Plan Termination

Coverage ends for the Group and members on the date the Plan ends except for the extended benefits stated in section 7.1. Moda Health may terminate the policy for fraud or intentional misrepresentation of material fact by the Group or for the Group's noncompliance with material policy provisions.

10.6.2 Termination by Subscriber

A subscriber may end their coverage, or coverage for any enrolled dependent, only at open enrollment or if there is a qualifying event. Qualifying events include marriage, divorce and birth. Coverage ends on the last day of the month through which premiums are paid.

10.6.3 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 if the requirements for continuation of coverage are met (see Section 13). 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.

10.6.4 Termination, Layoff or Reduction in Hours of Employment

Coverage ends on the last day of the month in which employment ends, unless a member chooses to continue coverage (see Section 13).

If a subscriber
a. is laid off by the Group; or
b. experiences a reduction in hours that causes a loss of coverage

And within 6 months the subscriber
a. returns to active work; or
b. has an increase in hours to qualify for benefits

The subscriber and any eligible dependents may enroll in the Plan on the date of rehire or the date the subscriber works enough hours to qualify, and coverage will begin on that date. The Group must notify Moda Health that the subscriber has been rehired following a layoff or that the subscriber's hours have been increased, and the necessary premiums for coverage must be

paid. Any waiting period required by the Plan will not have to be re-served. All plan provisions will resume at re-enrollment whether or not there was a lapse in coverage.

10.6.5 Loss of Eligibility by Dependent

Coverage ends on the last day of the month in which the dependent's eligibility ends.

a. Coverage ends for an enrolled spouse on the last day of the month in which a decree of divorce or annulment is entered (regardless of any appeal), or date of legal separation

b. Coverage ends for an enrolled child on the last day of the month in which

   i. the child turns age 26
   ii. the grandchild's parent is no longer a covered dependent of the subscriber
   iii. stepchild relationship ends due to divorce
   iv. legal guardianship ends

The subscriber must notify Moda Health when a marriage or guardianship ends.

Enrolled dependents may have the right to continue coverage in their own names when coverage under the Plan ends.

10.6.6 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 Group. This may include but is not limited to enrolling ineligible persons on the Plan, falsifying or withholding documentation that is the basis for eligibility or employment, and oral or written falsification or alteration of claims, including omission of information. Moda Health reserves the right to retain premiums paid as liquidated damages, and the Group and/or member shall be responsible for the full balance of any benefits paid. Moda Health will notify a member of a rescission 30 days before cancellation of coverage.

10.6.7 Continuing Coverage

Information is in Continuation of Health Coverage (Section 13).

SECTION 11. CLAIMS ADMINISTRATION & PAYMENT

11.1 SUBMISSION & PAYMENT OF CLAIMS

A claim is not payable until the service or supply has actually been received. In no event, except absence of legal capacity, is a claim valid if submitted later than 12 months from the date the expense was incurred.

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

Moda Health may pay benefits to the member, the provider or to both jointly.

11.1.1 Hospital & Professional Provider Claims

A member who is hospitalized or visits a professional provider must present their Moda Health identification card to the admitting office 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.

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

When a member is billed by the hospital or professional provider directly, they 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 CPT and/or Centers for Medicare and Medicaid HCPCS codes
f. Provider's tax ID number

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

For care received outside the United States see section 11.1.5.

11.1.2 Ambulance & Commercial Transportation Claims

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

11.1.3 Prescription Medication Claims

Members who go to an in-network pharmacy should present their Moda Health ID card and pay the required cost sharing. There will be 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 medication claim form, which is available on the Member Dashboard or by contacting Customer Service.

11.1.4 Vision Services Claims

A member who has vision services provided by an out-of-network provider or an in-network provider without benefit authorization will need to submit a request for reimbursement by completing the member reimbursement claim form, which is available by visiting www.vsp.com or calling 800-877-7195.

11.1.5 Out-of-Country or Foreign Claims

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

a. Patient's name, subscriber's name, and group and identification numbers
b. Statement explaining where the member was and why they sought care
c. Copy of the medical record (translated is preferred if available)
d. Itemized bill for each date of service
e. Proof of payment in the form of a credit card/bank statement or cancelled check, if there is no assignment of benefits

11.1.6 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 the Member Dashboard. Moda Health may pay claims, deny them, or apply the allowable expense toward satisfying any deductible. If all or part of a claim is denied, the reason will be stated in the EOB.

If a member does not receive an EOB or an email indicating that an EOB is available within a few weeks of the date of service, this may indicate that Moda Health has not received the claim. To be eligible for reimbursement, claims must be received within the claim submission period explained in section 11.1.

11.1.7 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.

11.1.8 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.

If more information is needed to process the claim for reasons beyond Moda Health's control, a notice will be sent to the member explaining what information is needed within 30 days after Moda Health receives the claim. The party responsible for providing the additional information will have 45 days to submit it. Moda Health will then finish processing the claim and send an EOB

to the member no later than 15 days after receiving the information or 30 days of original receipt of the claim.

If a claim is not processed timely, interest of 15% annually will accrue until processing of the claim is complete. Submission of information necessary to process a claim is also subject to the Plan's claim submission period explained in section 11.1.

11.1.9 Time Frames for Processing Prior Authorizations & Utilization Reviews

Any utilization review decision will be made within 5 business days after receipt of the request for prior authorization of nonemergency situations. For emergency situations, utilization review decisions for care following emergency services will be made as soon as is practicable but in any event no later than 24 hours after receiving the request for prior authorization or for coverage determination.

Any utilization review to deny, reduce, or terminate a health care benefit or to deny payment for a medical service because that service is not medically necessary shall be reviewed by a Moda Health employee or agent who holds the same or similar specialty as typically manages the medical condition, procedure or treatment under review.

A prior authorization for a covered medical procedure on the basis of medical necessity will not be retroactively denied unless the prior authorization is based on materially incomplete or inaccurate information provided by or on behalf of the provider.

11.2 Complaints, Appeals & External Review

Before filing an appeal, it may be possible to resolve a dispute with a phone call to Customer Service.

11.2.1 Definitions

For purposes of section 11.2, 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: 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 person's eligibility to participate in the Plan and one resulting from the application of any 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.

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 their representative for Moda Health to review an adverse benefit determination.

Appointed or Authorized Representative is a person appointed or authorized to represent a member in filing an appeal or complaint. A member may appoint any person (relative, friend, advocate, attorney, or physician). A surrogate may be authorized by the court or act in accordance with state law on behalf of the member (court-appointed guardian, one with

Durable Power of Attorney, healthcare proxy, or person designated under a healthcare consent statute).

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

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

Urgent care claims include requests involving a denial of coverage based on a determination that treatment was experimental or investigational. The member's physician must certify in writing that the recommended service or treatment that is the subject of the denial of coverage will be significantly less effective if not promptly initiated.

Complaint means an expression of dissatisfaction to Moda Health about any matter not involving an appeal or adverse benefit determination. Complaints may involve access to providers, waiting times, demeanor of medical care personnel, adequacy of facilities and quality of medical care. A complaint does not include a request for information or clarification about any subject related to the Plan.

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 and the services have not been received.

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

11.2.2 Time Limit for Submitting Appeals

Members have **180 days** from the date they receive notice 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 right to the appeal process may be lost. Members may file a written request for extension to the timeframes outlined in this section. The request must include at least one justification, with a fair and reasonable basis for allowing the extension.

11.2.3 The Review Process

The Plan has a 2-level internal review process consisting of a first level appeal and a voluntary second level appeal. If a member is not satisfied with the outcome of the first level appeal, and the dispute meets the specifications outlined in section 11.2.5, the member may request a second level appeal or an external review by an independent review organization. The first level of appeal must be exhausted to proceed to external review, unless Moda Health agrees otherwise. Moda Health will provide for a written decision by a Moda Health employee or agent who holds the same or similar specialty as would typically manage the case being reviewed. 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.

The timelines addressed in the sections below do not apply when the member does not reasonably cooperate or circumstances beyond the control of either party (Moda Health or the member) makes it impossible to comply with the requirement. Whoever is unable to comply must give notice of the specific reason to the other party as soon as possible when the issue arises.

A 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 their behalf.

11.2.4 First Level Appeals

An appeal must be submitted in writing. For claims involving urgent care, the appeal may be made by phone. If necessary, Customer Service can help with filing an appeal. Moda Health will acknowledge receipt of a written appeal and provide notice of the appeal provisions within 3 business days and conduct an investigation by persons who were not involved in the initial determination.

An appeal related to an urgent care claim can have a faster review upon request. Fast reviews will be finished within 72 hours in total for the first and second level appeals combined after 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.

For pre-service claims, investigations will be completed and a notice will be sent within 15 calendar days. For post-service claims, investigations will be completed and a notice sent within 30 calendar days.

When an investigation is finished, Moda Health will send a written notice of the decision to the member, including the reason for the decision. The notice on a decision regarding a utilization review issue will include the right to file a voluntary second level appeal and an external review.

11.2.5 Second Level Appeals

A member who disagrees with the decision regarding the first level appeal of a utilization review issue may request a review of the decision. The second level appeal is voluntary and 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. 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.

If the member elects to request a second level appeal, any statute of limitation or timeline pertaining to the rights for further review, such as external review or a lawsuit under ERISA Section 502(a), will be paused during the review process.

If the member chooses not to pursue the second level appeal, Moda Health waives any right to assert that the member failed to exhaust the internal review process should they elect to file a lawsuit in court under ERISA Section 502(a) following the first level appeal.

11.2.6 Appeals on Ongoing Care

If reducing or terminating an ongoing course of treatment before the end of the approved period of time or number of treatments, Moda Health will notify the member in advance and provide information about the right to appeal. Moda Health will provide continued coverage pending the outcome of an appeal. If the decision is upheld, the member is responsible for the cost not covered by Moda Health.

11.2.7 External Review

If the dispute meets the criteria below, a member may request that it be reviewed by an independent review organization (IRO) appointed by the Alaska Division of Insurance.

a. The member must sign a HIPAA release waiver allowing the IRO to see their medical records.
b. The dispute must relate to:
    i. An adverse benefit determination or final internal adverse benefit determination that involves medical judgment or rescission but does not include disputes about eligibility to participate in the Plan, except for those related to rescissions
    ii. Cases in which Moda Health fails to meet the internal timeline for review or the state or federal requirements for providing related information and notices
c. The request for external review must be made in writing to the director of the Alaska Division of Insurance no more than 180 days after receipt of the adverse benefit determination or the final internal adverse benefit determination. For expedited review, the request may be made by phone. A member may submit additional information to the IRO within 5 business days, or 24 hours for an expedited review. Members may file a written request for extension to the 180-day limit. The request must include at least one justification, with a fair and reasonable basis for allowing the extension.
d. The member must have finished the appeal process described in sections 11.2.4 and 11.2.5. However, Moda Health may waive this requirement and have an appeal referred directly to external review with the member's consent.
e. The member shall provide complete and accurate information to the IRO in a timely manner.

Moda Health will send a written notice to the member within 6 business days of receipt if the request is incomplete or ineligible for external review. Otherwise, the IRO will provide a written notice of the final external review decision no later than 45 days after its receipt of the request. If a request for an urgent care claim is incomplete or ineligible for external review, Moda Health will send a written notice to the member within 24 hours. Otherwise, the IRO will expedite the review and provide notice within 72 hours after its receipt of the request.

The decision of the IRO is binding except to the extent other remedies are available to the member under state or federal law, such as filing a civil suit in superior court.

11.2.8 Complaints

Moda Health will review complaints about the following issues when submitted in writing within 180 days from the date of the claim:

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

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

11.2.9 Additional Member Rights

Members may contact the Employee Benefits Security Administration at 866-444-3272 for questions about their appeal rights or for help.

Assistance may also be obtained from the Alaska Division of Insurance:

Phone: 907-269-7900 or toll free 800-467-8725
Fax: 907-269-7910
Mail: Division of Insurance
Consumer Services Section
550 West 7th Avenue, Suite 1560
Anchorage, AK 99501
Email: insurance@alaska.gov
Internet:www.commerce.alaska.gov/web/ins/Consumers/ConsumerComplaint.aspx

The first step of review must 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 state and federal law. The right to sue may be lost if the member has not used all of their internal appeal rights, which is generally required before filing a lawsuit.

11.3 Continuity of Care

If a member is being actively treated by an in-network provider at the time the professional provider's written agreement with the PPO network terminates, the member may continue to be treated by that professional provider for a limited period of time. During this time, Moda Health will consider the professional provider to still have an agreement with the PPO network only while the Plan remains in effect and

a. for the period that is the longest of the following:
    i. the end of the current plan year
    ii. up to 90 days after the termination date, if the event triggering the right to continuing treatment is part of an ongoing course of treatment
    iii. through completion of postpartum care, if the member is pregnant on the date of termination; or
b. until the end of the medically necessary treatment for the medical condition if the member has a terminal medical condition. In this paragraph, "terminal" means a life expectancy of less than one year.

11.4 Benefits Available from Other Sources

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

11.4.1 Coordination of Benefits (COB)

Coordination of benefits applies when a member has healthcare coverage under more than one plan.

If the member is covered by another plan or plans, the benefits under this Plan and the other plan(s) will be coordinated. This means one plan pays its full benefits first, and then any other plans pay. The order of benefit determination rules govern the order in which each plan will pay a claim for benefits. (For coordination with Medicare, see section 11.5.)

11.4.1.1 Order of Benefits Determination (Which Plan Pays First?)

When another plan does not have a COB provision, that plan is primary. When another plan does have a COB provision, the first of the following rules that applies will govern (see section 11.5 for coordination with Medicare):

a. **Non-dependent/Dependent.** If a plan covers the member as other than a dependent (e.g., an employee, member of an organization, primary insured, or retiree), then that plan will determine its benefits before a plan that covers the member as a dependent. However, if the member is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the member as a dependent and primary to the plan covering the member as other than a dependent (e.g., a retired employee), then the order of benefits between the 2 plans is reversed.

b. **Dependent Child/Parents Married or Living Together.** If the member is a dependent child whose parents are married or 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.) If another plan does not include this rule based on the parents' birthdays, but instead has a rule based on the gender of the parent, then that plan is the primary plan.

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. This rule applies to plan years beginning after the plan is given notice of the court decree.
   ii. If a court decree states that both parents are responsible for the healthcare expenses of the child, or that the parents have joint custody without specifying that one parent is responsible, the birthday rule described above applies.
   iii. If there is not a court decree allocating responsibility for the child's healthcare expenses, the order of benefits is as follows: The plan covering the
      A. Custodial parent
      B. Spouse or domestic partner of the custodial parent
      C. Non-custodial parent
      D. Spouse or domestic partner of the non-custodial parent

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.

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

f. **Active/Retired or Laid Off Employee.** The plan that covers a member as an active employee, (i.e., 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.
g. **COBRA or State Continuation Coverage.** If a member whose coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering that member as an employee, member of an organization, primary insured, or retiree or as a dependent of the same, is the primary plan and the COBRA or other continuation coverage is the secondary plan. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of the benefits, this rule is ignored.
h. **Longer/Shorter Length of Coverage.** The plan that covered a member longer is the primary plan and the plan that covered the member for the shorter period of time is the secondary plan.
i. **None of the Above.** If the preceding rules do not determine the order of benefits, the allowable expenses shall be shared equally between the plans. In addition, this Plan will not pay more than it would have paid if it had been the primary plan.

11.4.1.2 How COB Works

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 that pays benefits after the primary plan) will reduce the benefits it pays so that payments from all plans are not more than 100% of the total allowable expense.

If the primary plan is a closed panel plan and the secondary plan is not, 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.

11.4.1.3 COB and Plan Limits

If COB reduces the benefits payable under more than one plan provision, each benefit will be reduced proportionately. Only the reduced amount will be charged against any benefit limit in those plan provisions.

11.4.1.4 Pharmacy COB

Claims subject to the COB provision of the Plan may be submitted electronically by pharmacies or through the direct member reimbursement paper claim process. The preferred method is for the pharmacy to electronically transmit the primary plan's remaining balance to Moda Health for processing. If approved, the secondary claim will be automatically processed according to plan benefits. Members who are unable to have their secondary claims processed electronically may submit a claim reimbursement request directly to Moda Health (see section 11.1.3).

The way a pharmacy claim is paid by the primary payer will affect how Moda Health pays for the claim as the secondary plan.

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

Approved by Primary:

Primary plan does not pay anything toward the claim. Reasons for this may include the member has not satisfied a deductible or the cost of the medication is less than the primary plan's cost sharing. When this happens, Moda Health will pay as if it is primary.

Primary plan pays benefits. Moda Health will pay up to what the Plan would have allowed if it had been the primary payer. The Plan will not pay more than the member's total out of pocket expense under the primary plan.

11.4.1.5 Definitions

For purposes of section 11.4.1, the following definitions apply:

Plan means any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for covered persons in a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

Plan includes:

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

Plan does not include:

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

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

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

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

If a plan benefit has a visit, day or dollars paid limitation and the limitation has been met, services over the limitation will not be considered allowable expenses for the purpose of this provision.

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 policy may apply one COB provision to certain benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

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

Custodial parent is the parent awarded custody by a court decree. If there is no court decree, it is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

11.4.2 Third Party Liability

A member may have a legal right to recover benefit or healthcare costs from a third party as a result of a medical condition for which such costs were paid by Moda Health. The Plan does not cover benefits for which a third party may be legally liable. 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 Moda Health is entitled to be reimbursed in full from any recovery the member may receive for any benefits paid that are or may be recoverable from a third party or other source, no matter how the recovery is characterized.

The member agrees that Moda Health has the rights described in section 11.4.2. Moda Health may seek recovery under one or more of the procedures outlined in this section. The member agrees to do whatever is necessary to fully secure and protect, and to do nothing to prejudice, Moda Health's right of recovery or subrogation as discussed in this section.

11.4.2.1 Definitions

For purposes of section 11.4.2, 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 by a provider 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, personal injury protection (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 such an action) by or on behalf of a member, regardless of how the claims, 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, but only seek the recovery of non-economic damages. In that case, Moda Health is still entitled to recover benefits as described in section 11.4.2.)

11.4.2.2 Subrogation

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

11.4.2.3 Right of Recovery

In addition to its subrogation rights, Moda Health may, at its option, require a member, and their attorney, if any, to protect its recovery rights. The following rules apply:

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.

b. Moda Health is entitled to receive the amount of benefits it has paid for a medical condition out of any settlement or judgment that results from exercising the right of recovery against the third party. This is so whether or not the third party admits liability or claims that the member is also at fault. In addition, 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. If the Plan is subject to ERISA, the Plan is not responsible for and will not pay any fees or costs associated with the member pursuing a claim against a third party. The Plan is entitled to full reimbursement, without discount and without reduction for attorney fees and costs. Neither the "made-whole" rule nor the "common-fund doctrine" rule applies under the Plan. Only if the Plan is exempt from ERISA, the member may subtract from the money to be paid back to Moda Health a proportionate share of reasonable attorney fees as an expense for collecting from the other party.

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

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

11.4.2.4 Additional Provisions

Members shall comply with the following and agree that Moda Health may do one or more of the following, at its option:

a. The member shall cooperate with Moda Health to protect its recovery rights, including by:
   i. Signing and delivering any documents Moda Health reasonably requires to protect its rights, including a Third Party Reimbursement Questionnaire and Agreement. If the member has retained an attorney, then the attorney must also sign the agreement. Moda Health will not be required to pay benefits until the agreement is properly signed and returned
   ii. Providing any information to Moda Health relevant to the application of the provisions of section 11.4.2, including all information available to the member, or any representative or attorney representing the member, relating to the potential third party claim. This may include medical information, settlement correspondence, copies of pleadings or demands, and settlement agreements, releases or judgments
   iii. Notifying Moda Health of the potential third party claim for which the Plan may issue benefits. The member has this responsibility even if the first request for payment of benefits is a bill or invoice submitted to Moda Health by the member's provider
   iv. Taking such actions as Moda Health may reasonably request to assist it in enforcing its third party recovery rights

b. The member and their 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. By accepting 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.

d. The member agrees that Moda Health may notify any third party, or third party's representatives or insurers, of its recovery rights described in section 11.4.2.

e. Even without the member's written authorization, Moda Health may release to, or obtain from, any other insurer, organization or person, any information it needs to carry out the provisions of section 11.4.2.

f. Section 11.4.2 applies to any member for whom advance payment of benefits is made by the Plan whether or not the event giving rise to the member's injuries occurred before the member became covered by Moda Health.

g. If the member continues to receive 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.

h. If the member or the member's representatives fail to do any of the above mentioned acts, then Moda Health has the right to not advance payment or to suspend payment of any benefits, or to recover any benefits it has advanced, for any medical condition

resulting from the event giving rise to, or the allegations in, the third party claim. Moda Health may notify medical providers seeking authorization of payment of benefits that all payments have been suspended and may not be paid.

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

11.5 MEDICARE

The Plan coordinates benefits with Medicare as required under federal government rules and regulations. This includes coordinating the Medicare allowable amount. To the extent permitted by law, if the Plan is secondary to Medicare, the Plan will not pay for any part of a covered expense that is actually paid under Medicare or would have been paid under Medicare if the member had enrolled in Medicare when eligible. The Plan will estimate what Medicare would have paid and reduce its benefits based on the estimate. In addition, if the Plan is secondary to Medicare, Moda Health does not pay for any part of expenses incurred from providers who have opted out of Medicare participation.

The Plan may estimate Medicare's payment when:

a. The Plan is a retiree plan
b. The member is on COBRA (does not apply for ESRD, below)
c. The member is age 65 or older and the Group has fewer than 20 employees
d. The member is under age 65 and disabled
e. The member has end-stage renal disease (ESRD) and it is during the 30 months after they became eligible to enroll in Medicare.

A member who chose not to enroll in Medicare when first eligible or canceled Medicare after initial enrollment may have to pay any expenses not paid by the Plan.

Members with end-stage renal disease (ESRD) should enroll in Medicare as soon as they are eligible to do so.

SECTION 12. MISCELLANEOUS PROVISIONS

12.1 RIGHT TO COLLECT & RELEASE NEEDED INFORMATION

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

12.2 CONFIDENTIALITY OF MEMBER INFORMATION

Keeping a member's protected health information confidential is very important 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 detail about how Moda Health uses members' information. A copy of the notice is available on the Moda Health website by following the HIPAA link or by calling 855-425-4192.

12.3 TRANSFER OF BENEFITS

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

12.4 RECOVERY OF BENEFITS PAID BY MISTAKE

If Moda Health mistakenly makes a payment for a member to which they are not entitled, or pays a person who is not eligible for payments at all, Moda Health has the right to initiate recovery of the payment from the person paid or anyone else who benefited from it, including a provider, within 365 days of the date the original payment was made. 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. Moda Health will give a provider or member 30 calendar days written notice prior to recovering a payment. The provider or member has the right to challenge the recovery.

12.5 CORRECTION OF PAYMENTS

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

12.6 CONTRACT PROVISIONS

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

12.7 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 received, since all those who provide care do so as independent contractors. Moda Health cannot be held liable for any claim for damages connected with injuries a member suffers while receiving medical services or supplies.

12.8 WARRANTIES

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

12.9 NO WAIVER

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

12.10 GROUP IS THE AGENT

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

12.11 GOVERNING LAW

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

12.12 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 Alaska.

12.13 Time Limit 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 at least 60 days, but no more than 3 years, after the time the claim was filed (see section 11.1). All internal levels of appeal under the Plan must be exhausted before filing a legal action in court.

12.14 Evaluation of New Technology

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

SECTION 13. CONTINUATION OF HEALTH COVERAGE

The following sections on continuation of coverage may apply. Members should check with the Group to find out if they qualify for this coverage. Both subscribers and their dependents should read the following sections carefully.

13.1 COBRA CONTINUATION COVERAGE

13.1.1 Introduction

COBRA only applies to employers with 20 or more employees on 50% of the typical business days in the prior calendar year. Certain church plans are exempted from COBRA. Moda Health will provide COBRA continuation coverage to members who have experienced a qualifying event and 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 members who do not comply with the notice, election or other requirements outlined below
c. Moda Health will not provide COBRA coverage if the COBRA Administrator does not provide the required COBRA notices within the statutory time periods, or if the COBRA Administrator otherwise does not comply with any of the requirements outlined below
d. Moda Health will not provide a disability extension if the COBRA Administrator does not notify Moda Health within 60 days of its receipt of a disability extension notice from a member

For purposes of section 13.1, COBRA Administrator means either the Group or a third party administrator delegated by the Group to handle COBRA administration.

13.1.2 Qualifying Events

Subscriber. A subscriber may elect continuation coverage if coverage is lost because of termination of employment (other than termination for gross misconduct), 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. Death of the subscriber
b. Termination of the subscriber's employment (for reasons other than gross misconduct) or reduction in the subscriber's hours of employment with the Group
c. Divorce or legal separation from the subscriber
d. Subscriber becomes entitled to Medicare

If it can be established that a subscriber has eliminated coverage for their 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 divorce or legal separation, 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. Death of the subscriber
b. Termination of the subscriber's employment (for reasons other than gross misconduct) or reduction in the subscriber's hours of employment with the Group
c. Parents' divorce or legal separation
d. Subscriber becomes entitled to Medicare
e. Child ceases to be a "child" under the 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 their covered dependents.

13.1.3 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.

13.1.4 Notice and Election Requirements

Qualifying Event Notice. A dependent member's coverage ends 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 name of the Group; 2) the name and social security number of the affected members; 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 the 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) or 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 insurance coverage for these members will end.

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

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

13.1.5 COBRA Premiums

Members are responsible for all premiums for continuation coverage. Due to the 60-day election period, it is likely that retroactive premiums will be owed for the months between when regular coverage ended and the first payment date. These premiums must be paid in a lump sum at the first payment. The first payment for continuation coverage is due within 45 days after a member provides notice of electing coverage (this is the date the election notice is postmarked, if mailed, or the date the election notice is received by the COBRA Administrator, if hand-delivered). Subsequent payments are due on the first day of the month. 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 member is responsible for paying the applicable premiums when due; otherwise, continuation coverage will end and may not be reinstated. The premium rate may include a 2% add-on to cover administrative expenses.

13.1.6 Length of Continuation Coverage

18-Month Continuation Period. When coverage is lost 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. When coverage is lost 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 for members other than the subscriber who lose coverage as a result of the qualifying event can last up to 36 months after the date of Medicare entitlement. This COBRA coverage period is available only if the subscriber becomes entitled to Medicare within 18 months before the termination or reduction of hours.

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 their 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.

13.1.7 Extending the Length of COBRA Coverage

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

Disability. If any of the members is determined by the Social Security Administration to be disabled, the maximum COBRA coverage period that results from a subscriber's termination of employment or reduction of hours may be extended to a total of up to 29 months. The disability must have started before the 61st day of the COBRA coverage period and the Social Security Administration determination must be made before the end of the initial 18-month COBRA coverage period. Each family member who has elected COBRA coverage will be entitled to the disability extension if one of them qualifies.

The member must provide a copy of the Social Security Administration's determination of disability to the COBRA Administrator within 60 days after the latest of:

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

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

If the Social Security Administration determines the member is no longer disabled, the disability extension ends. The member must notify the COBRA Administrator no more than 30 days after the Social Security Administration's determination that they are no longer disabled.

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. 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 member to lose coverage under the Plan if the first qualifying event had not occurred. (This extension is not available under the Plan when a subscriber becomes entitled to Medicare after their termination of employment or reduction of hours.)

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

13.1.8 Special Enrollment & Open Enrollment

Members under continuation coverage have the same rights as similarly situated members who are not enrolled in COBRA. A member may add children or new spouses 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.

13.1.9 When Continuation Coverage Ends

COBRA coverage will end earlier than the maximum period if:

a. any required premiums are not paid in full on time
b. a member becomes covered under another group health plan
c. a member becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing COBRA (However, if the qualifying event is the Group's bankruptcy, the member will not lose COBRA because of entitlement to Medicare benefits)
d. the Group ceases to provide any group health plan for its employees
e. during a disability extension period (see section 13.1.7), the disabled member is determined by the Social Security Administration to be no longer disabled (COBRA coverage for all members, not just the disabled member, will end)

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

Questions about COBRA should be directed to the COBRA Administrator. The COBRA Administrator should be notified of any address change.

13.2 Uniformed Services Employment & Reemployment Rights Act (USERRA)

Coverage will end if a subscriber is called to active duty by any of the armed forces of the United States of America. However, if a subscriber asks 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 they return to active employment with the Group if released under honorable conditions, but only if they return to active employment:

a. On the first full business day following completion of 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 a medical condition 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 medical condition caused or aggravated by military service, as determined by the VA. Complete information regarding rights under USERRA is available from the Group.)

13.3 Family & Medical Leave

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

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

a. Affected members 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 group eligibility waiting period under the Plan will not be re-served
c. A subscriber's rights under family and medical leave will be governed by applicable state or federal statute and regulations

SECTION 14. 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 Group to find out if this section applies to their Plan.

14.1 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 for more information.

14.2 INFORMATION ABOUT THE PLAN AND BENEFITS

Subscribers may examine, without charge, at the Group'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 Group 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 Group is required by law to furnish each subscriber with a copy of this summary annual report.

14.3 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.

14.4 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 employer or any other person, may fire or discriminate against a member in any way to prevent a member from obtaining a benefit or exercising their rights under ERISA.

14.5 Enforcement of Rights

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

Under ERISA, there are steps members can take to enforce these rights. For instance, if a copy of plan documents or the latest annual report is requested from the Group and not received within 30 days, a member may file suit in federal court. In such a case, the court may require the Group to provide the materials and pay the member up to $110 a day until the member receives the materials, unless the materials were not sent because of reasons beyond the control of the Group. If a claim for benefits is denied or no action is taken, 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 11.2). 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 their 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 them to pay these costs and fees, (e.g., if it finds the claim is frivolous).

14.6 Assistance with Questions

For questions about this section or members' rights under ERISA, or for assistance obtaining documents from the Group, members should contact the Employee Benefits Security Administration, Seattle District Office, 300 Fifth Avenue, Suite 1110, Seattle, Washington, 98104, telephone 206-757-6781, or Office of Outreach, Education and Assistance, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington D.C. 20210, telephone 206-757-6781. Information and assistance is also available through their website: dol.gov/agencies/ebsa. Members may obtain publications about their rights and responsibilities under ERISA by calling the Office of Outreach, Education and Assistance.

SECTION 15. MEMBER DISCLOSURES

Members have the right to:

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

Members have the responsibility to:

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

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

Member rights under the Women's Health and Cancer Rights Act of 1998 (WHCRA)
The Plan provides benefits for mastectomy related services, including all states of reconstruction and surgery to achieve symmetry between the breasts, prostheses and complications resulting from a mastectomy, including lymphedema. Contact Customer Service for more information.

SECTION 16. DEFINITIONS

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

Applied Behavior Analysis (ABA) means a structured treatment program using behavioral principles to help children with autism spectrum disorder develop or maintain appropriate skills and behaviors. ABA is provided or supervised by certified or licensed behavior analysts.

Authorization see Prior Authorization.

Autism Service Provider means a Board Certified Behavior Analyst (BCBA), a Board Certified Assistant Behavior Analyst (BCaBA) practicing under the supervision of a BCBA, a Registered Behavior Technician (RBT) practicing under the supervision of a BCBA, or a state-licensed or state-certified healthcare professional providing services for autism spectrum disorder within the scope of their professional license.

Autism Spectrum Disorders has the meaning given in the most current edition of the Diagnostic and Statistical Manual of Mental Disorders.

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 including coverage remaining in force at the time a member obtains new coverage, as defined in 26 US Code §9801(c)(1).

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

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 which 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.

Eligible Employee means an employee of the Group who meets the eligibility requirements to be enrolled on the Plan (see section 10.1.)

Emergency Medical Condition means a medical condition with acute symptoms, including severe pain, that a prudent layperson with an average knowledge of health and medicine could reasonably expect would place the health of a member, or a fetus in the case of a pregnant member, in serious jeopardy without immediate medical attention.

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

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

Emergency services provided at an out-of-network emergency care facility also include post-stabilization services such as outpatient observation or an inpatient or outpatient stay with respect to the visit at the emergency care facility, except if the attending physician determines the member is able to travel using nonmedical or nonemergency medical transportation to an in-network facility, the out-of-network facility or provider meets the notice and consent requirements, and the member receives the notice and gives informed consent.

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.

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

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

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

Experimental or Investigational Medications are those that involve one or more of the following:

a. A medication, device (supply) or biologic product for which the approval of one or more government agencies (such as the FDA) is required, but has not been obtained at the time the treatment is requested or administered

b. A treatment for which scientific or medical assessment has not been completed, or the effectiveness of the treatment has not been generally established
c. Is only available in the United States as part of a clinical trial or research program for the illness or condition being treated
d. Is the subject of an on-going phase I or phase II clinical trial, or is the research/ experimental/study/investigational arm of an on-going phase III clinical trial
e. Is used within a regimen that may be individually proven, but when utilized in combination, scientific literature does not support the use
f. Is used within a regimen that is proven in combination with other medications, but when utilized individually, scientific literature does not support the use

First Choice Health Network is the network partnered with the Endeavor Select network. First Choice Network is a network of providers in Alaska, excluding Providence providers. Members searching for a particular provider should check the First Choice network at https://www.fchn.com/providersearch/moda-ak.

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

The **Group** is the organization whose employees are covered by the Plan.

Health Benefit Plan means an employee welfare benefit plan as defined in 29 U.S.C 1002(1) (Employee Retirement Income Security Act of 1974), and includes a plan, fund, or program established or maintained by a partnership, to the extent that the plan, fund, or program provides medical care, including items and services paid for as medical care, and any supplemental adult vision benefits, to employees, present or former partners, or their dependents, as defined under the terms of the plan, fund, or program, directly or through insurance, reimbursement, or other method. This Plan is a health benefit plan.

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

Implant means a material inserted or grafted into tissue.

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

In-Network refers to providers that are contracted under Moda Health or Delta Dental to provide care to members.

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

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

MPA for out-of-network providers in Alaska other than a facility is the lesser of billed charges or the 80th percentile of fees commonly charged for a given procedure in a given area, based on a national database.

Charges for services by an out-of-network provider outside of Alaska other than a facility will be paid at the out-of-network benefit level, and the MPA is the lesser of supplemental provider fee arrangements Moda Health may have in place and the 80th percentile of fees commonly charged for a given procedure in a given area, based on a national database.

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

MPA for out-of-network services under the vision benefit is the lesser of the provider's billed charges or the 80th percentile of fees commonly charged for a given procedure in a given area.

MPA for out-of-network facilities such as hospitals, ambulatory surgical centers, home health providers, skilled nursing facilities, and residential treatment programs is the lesser of supplemental facility or provider fee arrangements Moda Health may have in place, the 80th percentile of fees commonly charged for a given procedure in a given area based on a national database, or the billed charge.

MPA for emergency services received out-of-network, out-of-network air ambulance, or out-of-network services in an in-network facility where the member is not able to choose the provider 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 out-of-network end-stage renal disease (ESRD) facilities is 125% of the Medicare allowable amount for members eligible for Medicare.

MPA for prescription medications at out-of-network pharmacies is no more than the average wholesale price (AWP) accessed by Moda Health minus a percentage discount. Reimbursement for medications dispensed by all other providers will be subject to the Plan's benefit provisions 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 may be the member's responsibility (this is the balance billing amount) unless balance billing is prohibited by federal law.

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. Genetic information in and of itself is not a condition.

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

a. It agrees with standards that are based on credible scientific evidence published in peer reviewed medical literature in relation to effectiveness for services, medications and interventions for medical condition and patient indications
b. It is consistent with the symptoms or diagnosis of the member's condition and appropriate considering the potential benefit and harm to the patient
c. The service, medication, supply or intervention is known to be effective in improving health outcomes
d. The service, medication, supply or intervention is cost-effective compared to the alternative intervention, including no intervention

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

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

Medically necessary care does not include custodial care.

More information about medical necessity can be found in the General Exclusions (Section 8).

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

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

Mental Health Condition means any mental health disorder covered by the diagnostic categories listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders.

Mental Health Provider means a board-certified psychiatrist, or any of the following state-licensed professionals: a psychologist, a psychologist associate, a mental health nurse practitioner, a clinical social worker, a professional counselor, a mental health counselor, a marriage and family therapist, a psychiatric mental health clinical nurse specialist or a master social worker.

Moda Health refers to Moda Health Plan, Inc.

Network means a group of providers who contract to provide healthcare to members at negotiated rates. Such groups are called Preferred Provider Organizations (PPOs), and provide in-network services in their specific service areas. Covered medical expenses will be paid at a higher rate when an in-network provider is used (see Section 3).

Out-of-Network refers to providers that are not contracted under Moda Health or Delta Dental to provide benefits with discounted rates to members.

Out-of-Pocket Maximum means the maximum amount a member pays out-of-pocket every year, including the deductible, coinsurance and copays. If a member obtains both in-network and out-of-network services, 2 separate out-of-pocket maximums apply. If a member reaches the out-of-pocket maximum in a calendar year, the Plan will pay 100% of eligible expenses for the rest of the year.

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

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

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

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

Prior Authorization or **Prior Authorized** refers to obtaining approval by Moda Health before the date of service. A complete list of services and medications that require prior authorization is available on the Member Dashboard or by contacting Customer Service. Failure to obtain required authorization will result in denial of benefits or a penalty (see section 6.1).

Private Healthcare Systems (PHCS), is the national network partnered with the Endeavor Select network in the service area outside of Alaska. Although all PHCS providers are part of the Endeavor Select network, not all PHCS providers are loaded into the Endeavor Select network system at this time. Members searching for a particular provider who is not listed in the Endeavor Select network should check the PHCS network as well.

Professional Provider means an autism service provider as defined above or any state-licensed or state-certified health care professionals, when providing medically necessary services within the scope of their licenses or certifications. In all cases, the services must be covered under the Plan to be eligible for benefits.

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

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

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

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

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

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

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.

TruHearing refers to the hearing services network of audiologists and hearing instrument providers covered at in-network benefit level.

Urgent Care Facility is an outpatient facility or clinic that uses the CMS place of service code in their claim billing to specify the services were performed in an urgent care facility. It is a location distinct from a hospital emergency room, an office or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled ambulatory patients seeking immediate medical attention. Most walk-in clinics and immediate care facilities do not bill with the place of service code that is designated for urgent care facilities.

VSP refers to the vision care network of providers covered at in-network benefit level.

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

Nondiscrimination notice

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

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

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

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

888-217-2363 (TDD/TTY 711)

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

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

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

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

U.S. Department of Health
and Human Services
200 Independence Ave. SW, Room 509F
HHH Building, Washington, DC 20201

800-368-1019, 800-537-7697 (TDD)

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

Dave Nesseler-Cass coordinates our nondiscrimination work:

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

moda HEALTH

DELTA DENTAL
Delta Dental of Oregon & Alaska

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

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

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

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

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

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

توجہ دیں: اگر آپ اردو (URDU) بولتے ہیں تو لسانی اعانت آپ کے لیے بلا معاوضہ دستیاب ہے۔ پر کال کریں (TTY: 711) 1-877-605-3229

ВНИМАНИЕ! Если Вы говорите по-русски, воспользуйтесь бесплатной языковой поддержкой. Позвоните по тел. 1-877-605-3229 (текстовый телефон: 711).

ATTENTION : si vous êtes locuteurs francophones, le service d'assistance linguistique gratuit est disponible. Appelez au 1-877-605-3229 (TTY : 711)

توجه: در صورتی که به فارسی صحبت می کنید، خدمات ترجمه به صورت رایگان برای شما موجود است. با 1-877-605-3229 (TTY: 711) تماس بگیرید.

ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपको भाषाई सहायता बिना कोई पैसा दिए उपलब्ध है। 1-877-605-3229 पर कॉल करें (TTY: 711)

Achtung: Falls Sie Deutsch sprechen, stehen Ihnen kostenlos Sprachassistenzdienste zur Verfügung. Rufen sie 1-877-605-3229 (TTY: 711)

注意：日本語をご希望の方には、日本語サービスを無料で提供しております。1-877-605-3229（TYY、テレタイプライターをご利用の方は711）までお電話ください。

modahealth.com

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અગત્યનું: જો તમે (ભાષાંતર કરેલ ભાષા અહીં દર્શાવો) બોલો છો તો તે ભાષામાં તમારે માટે વિના મૂલ્યે સહાય ઉપલબ્ધ છે. 1-877-605-3229 (TTY: 711) પર કૉલ કરો

ໂປດຊາບ: ຖ້າທ່ານເວົ້າພາສາລາວ, ການຊ່ວຍເຫຼືອດ້ານພາສາແມ່ນມີໃຫ້ທ່ານໂດຍບໍ່ເສັຍຄ່າ. ໂທ 1-877-605-3229 (TTY: 711)

УВАГА! Якщо ви говорите українською, для вас доступні безкоштовні консультації рідною мовою. Зателефонуйте 1-877-605-3229 (TTY: 711)

ATENȚIE: Dacă vorbiți limba română, vă punem la dispoziție serviciul de asistență lingvistică în mod gratuit. Sunați la 1-877-605-3229 (TTY 711)

THOV CEEB TOOM: Yog hais tias koj hais lus Hmoob, muaj cov kev pab cuam txhais lus, pub dawb rau koj. Hu rau 1-877-605-3229 (TTY: 711)

ត្រូវចងចាំ៖ បើអ្នកនិយាយភាសាខ្មែរ ហើយត្រូវការសេវាកម្មជំនួយផ្នែកភាសាដោយឥតគិតថ្លៃ គឺមានផ្តល់ជូនលោកអ្នក។ សូមទូរស័ព្ទទៅកាន់លេខ 1-877-605-3229 (TTY: 711)

HUBACHIISA: Yoo afaan Kshtik kan dubbattan ta'e tajaajiloonni gargaarsaa isiniif jira 1-877-605-3229 (TTY:711) tiin bilbilaa.

โปรดทราบ: หากคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือด้านภาษาได้ฟรี โทร 1-877-605-3229 (TTY: 711)

FA'AUTAGIA: Afai e te tautala i le gagana Samoa, o loo avanoa fesoasoani tau gagana mo oe e le totogia. Vala'au i le 1-877-605-3229 (TTY: 711)

IPANGAG: Nu agsasaoka iti Ilocano, sidadaan ti tulong iti lengguahe para kenka nga awan bayadna. Umawag iti 1-877-605-3229 (TTY: 711)

UWAGA: Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń: 1-877-605-3229 (obsługa TTY: 711)

moda HEALTH

DELTA DENTAL

Delta Dental of Oregon & Alaska

For help, call us directly at 888-873-1395.
(En Español: 888-786-7461)

P.O. Box 40384
Portland, OR 97240

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