2025

Alaska Group Medical Plan

Group Name
Pioneer Gold 1000
Effective Date: *January 1, 2025*
Group Number: *123456789*

Health plans in Alaska provided by Moda Health Plan, Inc.

moda HEALTH

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TABLE OF CONTENTS

SECTION 1. WELCOME TO MODA HEALTH

We are pleased your Group has chosen Moda Health as its preferred provider organization (PPO) plan. This handbook will give you important information about the Plan's benefits, limitations and procedures.

If you have questions, call one of the numbers listed in section 2.1 or use the tools and resources on your Member Dashboard, atwww.modahealth.com. You can use it 24 hours a day, 7 days a week to get your plan information whenever it is convenient. If an interpreter is necessary, Customer Service will coordinate the services of an interpreter over the phone.

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

This handbook may be changed or replaced at any time, by the Group or Moda Health, without your agreement. You can find the most current handbook on your Member Dashboard. 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
Some of the things you can do on your Member Dashboard are:

- Find a Tier 1 and Tier 2 provider with Find Care
- Get medication cost estimates and benefit tiers using our Prescription Price Check tool and formulary
- See if a service or supply you need must be prior authorized first www.modahealth.com/medical/referral

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

Behavioral Health Customer Service Department
Toll-free 800-799-9391

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

Disease Management and Health Coaching
Toll-free 800-913-4957

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
VSP
Toll-free 800-877-7195

Telecommunications Relay Service for the hearing impaired
711

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

2.2 Member ID Card

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

2.3 Networks And Tier 2 Providers

Network Information (Section 5) explains how networks work.

Medical networks
Tier 1: Pioneer
Tier 2: First Choice in Alaska and Connexus

Dental network
Delta Dental Premier

Pharmacy network
Navitus

Travel network
Aetna® PPO
https://www.aetna.com/asa

Vision network
VSP

2.4 Care Coordination

2.4.1 Care Coordination

When you have a complex and/or catastrophic medical situation, our Care Coordinators and Case Managers will work directly with you and your professional providers to coordinate your healthcare needs. Care Coordinators and Case Managers are nurses or behavioral health clinicians. They will coordinate access to a wide range of services spanning all levels of care, including medical travel support to a preferred provider (see 7.4.23). Coordinating your care helps you get the right services at the right time.

2.4.2 Disease Management & Health Coaching

If you are living with a chronic disease or medical condition, we want to help you improve your health status, quality of life and productivity.

Working with a Health Coach can help you follow the medical care plan your professional provider recommends. Health Coaches provide education and support to help you identify your healthcare goals, self-manage your disease and prevent the development or progression of complications. Contact Disease Management and Health Coaching for more information.

2.4.3 Behavioral Health

Moda Behavioral Health provides specialty services for managing mental health and substance use disorder benefits. We can help you access effective care in the right place and contain costs. Behavioral Health Customer Service can help you find Tier 1 and Tier 2 providers and understand your 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 13.

SECTION 3. SCHEDULE OF BENEFITS

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

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

You will find details of the actual benefits in the sections after this summary. You will need to know the conditions, limitations and exclusions that are explained there. Prior authorization may be required for some services (see section 6.1). Important terms are explained in Section 12.

Cost sharing is the amount you pay. See Section 4 for more information, including an explanation of deductible and out-of-pocket maximum. For services provided at Tier 3, you have to pay any amount over the maximum plan allowance.

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

	Tier 1 Benefits	**Tier 2 Benefits**	**Tier 3 Benefits**
Annual deductible per member	**$1,000**, Tier 2 deductible applies	**$2,000**, Tier 1 deductible applies	**$4,000**
Annual deductible per family	**$2,000**, Tier 2 deductible applies	**$4,000**, Tier 1 deductible applies	**$8,000**
Annual out-of-pocket maximum per member	**$4,000**, Tier 2 out-of-pocket maximum applies	**$6,000**, Tier 1 out-of-pocket maximum applies	**$45,000**
Maximum annual out-of-pocket maximum per family	**$8,000**, Tier 2 out-of-pocket maximum applies	**$12,000**, Tier 1 out-of-pocket maximum applies	**$90,000**

Services	Amount You Pay			Section in Handbook & Details
	Tier 1	**Tier 2**	**Tier 3**	
Urgent & Emergency Care				
Ambulance Transportation	20% after deductible Tier 1 deductible and out-of-pocket maximum apply			Section 7.2.1
Non-emergent Air Ambulance Services	20% after deductible	40% after deductible	60% after deductible	Section 7.2.1
Commercial Transportation	20% after deductible	20% after deductible	20% after deductible	Section 7.2.2 One-way for sudden, life-endangering medical condition. (Tier 1 deductible and out-of-pocket maximum apply)
Emergency Room Facility (includes ancillary services)	$250 per visit, then 20% after deductible Tier 1 deductible and out-of-pocket maximum apply			Section 7.2 and 7.2.4 No copay if admitted to hospital from emergency room
ER professional/ ancillary services billed separately	20% after deductible Tier 1 deductible and out-of-pocket maximum apply			No deductible for diagnostic x-ray and lab
Urgent Care Office Visits	$50 per visit	40% after deductible	60% after deductible	Section 7.2.5
Medical Transportation	20% after deductible	20% after deductible	20% after deductible	Section 7.2.3 2 round-trip tickets per year
Preventive Services				
Services as required under the Affordable Care Act, including:	0%	0%	60% after deductible	Section 7.3 See section for frequency and age limitations
Colonoscopy	0%	0%	60% after deductible	Section 7.3.1 One per 10 years, age 45+
Contraception	0%	0%	60% after deductible	Section 7.3.2
Hearing Screening	0%	0%	60% after deductible	Section 7.3.4 Initial screening within 30 days of birth Additional tests up to age 24 months
Immunizations	0%	0%	60% after deductible	Section 7.3.3

Services	Amount You Pay			Section in Handbook & Details
	Tier 1	**Tier 2**	**Tier 3**	
Mammogram	0%	0%	0%	Section 7.3.8 One age 35 - 40 One per year, age 40+
Preventive Health Exams	$0 per visit	$0 per visit	60% after deductible	Section 7.3.5 3 exams age 2 - 4 One per year, age 5+
Well-Baby Exams	$0 per visit	$0 per visit	60% after deductible	Section 7.3.7 First 24 months of life
Women's Exam & Pap Test	$0 per visit	$0 per visit	60% after deductible	Section 7.3.8 One per year
Vision Screening	0%	0%	60% after deductible	Section 7.3.4 Age 3 - 5
Other Preventive Services including:				
Screening X-ray & Lab	20%	40% after deductible	60% after deductible	
Prostate Rectal Exam	$25 per visit	40% after deductible	60% after deductible	Section 7.3.6 One per year, age 40+
Prostate Specific Antigen (PSA) Test	20%	40% after deductible	60% after deductible	
General Treatment Services				
Acupuncture	$25 per visit	40% after deductible	60% after deductible	Section 7.4.1 24 visits per year
Anticancer Medication	20% after deductible	40% after deductible	60% after deductible	Section 7.4.2
Applied Behavior Analysis	20% after deductible	40% after deductible	60% after deductible	Section 7.4.3
Behavioral Health Services				Section 7.4.4
Detoxification (Detox)	20% after deductible	40% after deductible	60% after deductible	$5 no deductible for first 3 office visits, including PCP and behavioral health office visits
Office Visits	$50 per visit	40% after deductible	60% after deductible	
Intensive Outpatient	$50 per visit	40% after deductible	60% after deductible	
Other Outpatient Services	20% after deductible	40% after deductible	60% after deductible	
Inpatient	20% after deductible	40% after deductible	60% after deductible	
Partial Hospitalization	20% after deductible	40% after deductible	60% after deductible	
Residential Treatment Program	20% after deductible	40% after deductible	60% after deductible	
Biofeedback	20% after deductible	40% after deductible	60% after deductible	Section 7.4.5 10 visit lifetime maximum

Services	Amount You Pay			Section in Handbook & Details
	Tier 1	**Tier 2**	**Tier 3**	
Dental Care				Section 7.4.8 Under age 19 Frequency limits apply to some services
Diagnostic & Preventive	0%	0%	50% after deductible	
Minor restorative services	20% after deductible	20% after deductible	50% after deductible	
Other dental services	50% after deductible	50% after deductible	50% after deductible	
Orthodontia	50% after deductible	50% after deductible	50% after deductible	When medically necessary
Dental Injury	20% after deductible	40% after deductible	60% after deductible	Section 7.4.9
Diabetes Services	20% after deductible	40% after deductible	60% after deductible	Section 7.4.10 Supplies covered under Pharmacy benefits
Diagnostic Procedures, including x-ray & lab				Section 7.4.11
Outpatient	20%	40% after deductible	60% after deductible	
Inpatient	20% after deductible	40% after deductible	60% after deductible	
Advanced Imaging	20% after deductible	40% after deductible	60% after deductible	
Durable Medical Equipment (DME), Supplies & Appliances	20% after deductible	40% after deductible	60% after deductible	Section 7.4.12 Limits apply to some DME, supplies, appliances
Home Healthcare	20% after deductible	40% after deductible	60% after deductible	Section 7.4.16 130 visits per year
Hospice Care				Section 7.4.17
Home Care	20% after deductible	40% after deductible	60% after deductible	
Inpatient Care	20% after deductible	40% after deductible	60% after deductible	10 days
Respite Care	20% after deductible	40% after deductible	60% after deductible	240 hours
Hospital Inpatient Care	20% after deductible	40% after deductible	60% after deductible	Section 7.4.18
Hospital Physician Visits	20% after deductible	40% after deductible	60% after deductible	Section 7.4.19
Infusion Therapy (Home or Outpatient)	20% after deductible	40% after deductible	60% after deductible	Section 7.4.20
Kidney Dialysis	20% after deductible	40% after deductible	60% after deductible	Section 7.4.21

Services	Amount You Pay			Section in Handbook & Details
	Tier 1	**Tier 2**	**Tier 3**	
Massage Therapy	$25 per visit	40% after deductible	60% after deductible	Section 7.4.22 24 visits per year
Medical Travel Support				Section 7.4.23
Procedure	0%	N/A	N/A	Through Surgery Care
Travel and Lodging	0%	N/A	N/A	
Nutritional Therapy	20% after deductible	40% after deductible	60% after deductible	Section 7.4.26
Office & Home Visits				Section 7.4.27 See also Virtual Care Visits Naturopathic physicians are considered specialists unless credentialed as a PCP
PCP Visits				
First 3 PCP visits	$5 per visit	40% after deductible	60% after deductible	
Additional PCP visits	$25 per visit	40% after deductible	60% after deductible	
Specialist Visits	$50 per visit	40% after deductible	60% after deductible	Section 7.4.27
Psychological or Neuropsychological Testing	20%	40% after deductible	60% after deductible	Section 7.4.31 12 hours per year
Outpatient Rehabilitation & Habilitation	$50 per visit	40% after deductible	60% after deductible	Section 7.4.33 45 sessions per year. Limits apply separately to rehabilitation and habilitation services.
Inpatient Rehabilitation	20% after deductible	40% after deductible	60% after deductible	Section 7.4.32 30 days per year
Skilled Nursing Facility Care	20% after deductible	40% after deductible	60% after deductible	Section 7.4.34 60 days per year
Spinal Manipulation	$25 per visit	40% after deductible	60% after deductible	Section 7.4.35 24 visits per year
Surgery & Invasive Diagnostic Procedures				Section 7.4.36
Outpatient	20% after deductible	40% after deductible	60% after deductible	
Inpatient	20% after deductible	40% after deductible	60% after deductible	
Therapeutic Injections	20% after deductible	40% after deductible	60% after deductible	Section 7.4.37
Therapeutic Radiology	20% after deductible	40% after deductible	60% after deductible	Section 7.4.38

Services	Amount You Pay			Section in Handbook & Details
	Tier 1	**Tier 2**	**Tier 3**	
Transplants				Section 7.4.39 Includes donor costs
Center of Excellence facilities	20% after deductible	N/A	N/A	
Other facilities	Not covered	Not covered	Not covered	
Travel, Lodging & Meals	20% after deductible	20% after deductible	20% after deductible	$7,500 per transplant
Virtual Care Visits				Section 7.4.40 First 3 visits combined with in person visits (PCP and behavioral health)
First 3 visits	$5 per visit	40% after deductible	60% after deductible	
Additional visits	$25 per visit	40% after deductible	60% after deductible	
Through CirrusMD	$0 per visit	N/A	N/A	Log on via modahealth.com/cirrusmd
Maternity Services				
Breastfeeding				Section 7.5.2
Support & Counseling	0%	0%	60% after deductible	
Supplies		0%	0%	
Maternity	20% after deductible	40% after deductible	60% after deductible	Section 7.5
Pharmacy				
Prescription Medications	If you use an out-of-network pharmacy, you must pay any amounts charged above the MPA			Section 7.6 Up to 90-day supply for retail and mail order One copay for each 30-day supply
Retail Pharmacy				
Value Tier	$0		$0	
Select Tier	$15		$15	
Preferred Tier	$30		$30	
Nonpreferred Tier	$100		$100	
Mail Order Pharmacy				
Value Tier	$0		Must use a Moda-designated mail order pharmacy	
Select Tier	$45			
Preferred Tier	$90			
Nonpreferred Tier	$300			

Services	Amount You Pay			Section in Handbook & Details
	Tier 1	**Tier 2**	**Tier 3**	
Specialty Pharmacy				Up to 30-day supply per prescription for most medications Must use a Moda-designated specialty pharmacy
Preferred Specialty	20% after deductible	20% after deductible	N/A	
Nonpreferred Specialty	50% after deductible	50% after deductible	N/A	
Anticancer Medication	20% after deductible	20% after deductible	20% after deductible	Section 7.4.2 Pharmacy tier deductible applies Must use a Moda-designated pharmacy for mail order and specialty
Vision Care				
Pediatric Vision Care				Section 7.7.1 Under age 19
Exam	$0 per visit		50%	One per year
Lenses & frames or contacts	0%		50%	One pair per year Frames from the Otis & Piper collection only
Optional Lenses and Treatments	0%		50%	
Low vision evaluation	0%		50%	One every year
Low vision services	0%		50%	4 visits every 5 years for follow up care
Low vision aids	0%		50%	One low vision aid per year and one pair of high power spectacles per year
Adult Vision Services				Section 7.7.2 Age 19+
Well-vision exam	$10 per visit		50%	One per year
Lenses & frames	$25		50%	One pair lenses per year and one pair frames every 2 years Tier 1 and Tier 2 frames up to $130 maximum

$15
$30

Services	Amount You Pay			Section in Handbook & Details
	Tier 1	Tier 2	Tier 3	
Contacts (elective) including contact lens exam	0%		50%	Once per year, in lieu of frames and lenses Tier 1 and Tier 2 up to $130 maximum
Contacts (medically necessary) including contact lens exam	$25		50%	In lieu of frames and lenses
Low vision testing	0%		50%	Low vision tests twice every 2 years
Low vision aids	25%		50%	Tier 1 and 2 up to $1,000 maximum every 2 years for all services, testing and aids.
Hearing Coverage				
Hearing exam	20%		20%	Section 7.8 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%		20%	

SECTION 4. PAYMENT & COST SHARING

4.1 DEDUCTIBLES

Every year, you 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 a Tier 1 benefit. You must pay all covered expenses until you have spent the deductible amount, unless the Plan specifically says there is no deductible. Then the Plan begins sharing costs with you.

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 you pay after the deductible is met, are shown in Section 3. Services accumulated toward the Tier 1 deductible can be used to satisfy the Tier 2 deductible, and services accumulated toward the Tier 2 deductible can be used to satisfy the Tier 1 deductible. Tier 3 amounts accumulate separately. If more than one member of your family is covered, you only have to pay your per member deductible until the total family deductible is reached.

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

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

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

4.2 ANNUAL MAXIMUM OUT-OF-POCKET

The Plan helps protect you from very high medical costs. The out-of-pocket maximum is an upper limit on how much you have to pay for covered charges each year. Once you have paid the maximum amount, the Plan will pay 100% of covered services for the rest of the year. If more than one member of your family is covered, the per member maximum applies only until the total family out-of-pocket maximum is reached, even if no single family member has reached the per member maximum. Services accumulated toward the Tier 1 out-of-pocket maximum can be used to satisfy the Tier 2 out-of-pocket maximum. Services accumulated toward the Tier 2 out-of-pocket maximum can be used to satisfy the Tier 1 out-of-pocket maximum. The Tier 3 maximum accumulates separately.

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

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

You will always have to pay the following disallowed charges, even after your out-of-pocket maximum is met:

a. Cost containment penalties
b. Disallowed charges
c. Tier 3 vision benefits if you are under age 19
d. Vision benefits if you are over age 18
e. Hearing coverage benefits

If the Group has changed coverage to a policy with Moda Health, we will credit any out-of-pocket maximum amount you met under your old plan during the year to your new Moda Health Plan.

4.3 PAYMENT

Expenses allowed by Moda Health are based upon the maximum plan allowance (MPA), which is a contracted fee for Tier 1 and Tier 2 providers. For Tier 3 providers the MPA is an amount established, reviewed, and updated by a national database (see Section 12). You may have to pay some of the charges (cost sharing). What you have to pay depends on the Plan provisions.

Except for cost sharing and Plan benefit limitations, Tier 1 and Tier 2 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

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

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

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

SECTION 5. NETWORK INFORMATION

Tier 1 benefits apply to services delivered by Tier 1 providers in Municipality of Anchorage, Fairbanks North Star, Haines, Kenai Peninsula, Ketchikan Gateway, Matanuska-Susitna, Petersburg and Municipality of Skagway boroughs, City and Borough of Juneau, City and Borough of Sitka, City and Borough of Wrangell, Hoonah-Angoon Census Area and Prince of Wales-Hyder Census Area; Tier 2 benefits apply to services delivered by Tier 2 providers in Alaska; Tier 3 benefits apply to services delivered by Tier 3 providers. By using a Tier 1 provider, you will receive quality healthcare and will have the highest level of benefits. Services you receive in a Tier 1 or Tier 2 facility may be provided by physicians, anesthesiologists, radiologists or other professionals who are Tier 3 providers. When you receive services from Tier 3 providers, any amounts charged above the MPA may be your responsibility. This is called balance billing. Services received outside the state of Alaska are covered at the Tier 1 benefit level for emergency services.

Remember to ask providers to send any lab work or x-rays to a Tier 1 facility for the highest benefits. You may choose a Tier 1 provider in the Pioneer network by using Find Care on your Member Dashboard or a Tier 2 provider in First Choice Health network in Alaska by searching at https://www.fchn.com/providersearch/moda-ak. You may contact Customer Service if you need help. Your member ID cards will list your network.

5.1 General Network Information

5.1.1 Network and Service Area

You have access to a primary network, Pioneer, which provides services in Municipality of Anchorage, Fairbanks North Star, Haines, Kenai Peninsula, Ketchikan Gateway, Matanuska-Susitna, Petersburg and Municipality of Skagway boroughs, City and Borough of Juneau, City and Borough of Sitka, City and Borough of Wrangell, Hoonah-Angoon Census Area and Prince of Wales-Hyder Census Area, also known as your service area. If you move outside of the service area, you will lose eligibility on the Plan.

Networks

For all members:

a. Medical network is Pioneer in Municipality of Anchorage, Fairbanks North Star, Haines, Kenai Peninsula, Ketchikan Gateway, Matanuska-Susitna, Petersburg and Municipality of Skagway boroughs, City and Borough of Juneau, City and Borough of Sitka, City and Borough of Wrangell, Hoonah-Angoon Census Area and Prince of Wales-Hyder Census Area. The Plan also provides supplemental network coverage through First Choice in Alaska:
    1. Pioneer (Tier 1): Tier 1 preferred medical providers and facilities and select specialists from First Choice network
       First Choice (Tier 2): First Choice providers in Alaska and Connexus
b. Pharmacy network is Navitus
c. Vision network is VSP
d. Dental network is Delta Dental Premier

When there is no reasonable access within 50 miles from your residence to a Tier 1 provider, you can receive services from a Tier 2 provider in Municipality of Anchorage, Fairbanks North Star, Haines, Kenai Peninsula, Ketchikan Gateway, Matanuska-Susitna, Petersburg and Municipality of Skagway boroughs, City and Borough of Juneau, City and Borough of Sitka, City and Borough of Wrangell, Hoonah-Angoon Census Area and Prince of Wales-Hyder Census Area at the Tier 1

level. If there is a Tier 1 provider available within 50 miles, the services will be paid at the Tier 2 benefit level.

5.1.2 Travel Network

When you are traveling outside of Alaska, you may receive benefits at the Tier 1 level when you use a provider from the travel network for urgent or emergency services. The Tier 1 benefit level only applies to a travel network provider if you are outside the state of Alaska and the travel is not for the purpose of receiving treatment or benefits (medical tourism). The travel network is not available if you are temporarily living outside the service area.

Travel Network
Aetna® PPO

Find a travel network provider by using Find Care on your Member Dashboard, by searching via https://www.aetna.com/asa or by contacting Customer Service for assistance.

5.1.3 Out-of-Network (Tier 3) Care

In Alaska, when you choose healthcare providers that are not in Tier 1 or Tier 2, your benefits are lower, at the Tier 3 benefit level shown in Section 3. In most cases you must pay the provider all charges when you get the treatment, and then file a claim to get your out-of-network benefits. If the provider's charges are more than the maximum plan allowance, you are responsible for paying those excess charges.

When there is no reasonable access within 50 miles from your residence to a Tier 1 or Tier 2 provider, you can receive services from a Tier 3 provider in Alaska at the Tier 1 benefit level. If there is a Tier 1 or Tier 2 provider available within 50 miles, the services will be paid at the Tier 3 benefit level.

The Plan does not cover services provided outside of Alaska except for the following:

a. Emergency services
b. Coverage through the travel network
c. Coverage through medical travel support (see section 7.4.23)
d. Coverage through out-of-state contracted providers
e. Medically necessary non-emergency services that are prior authorized by Moda Health (see section 6.1)

These services are covered at the Tier 1 member cost sharing. You are responsible for any amount over the maximum plan allowance. If your prior authorized services are available in-network and you choose an out-of-network provider, coverage will be at the out-of-network (Tier 3) benefit level.

5.1.4 Care After Normal Office Hours

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

5.2 Using Find Care

Find Care is our online directory of Tier 1 and Tier 2 providers. To search for Tier 1 providers, log in to your Member Dashboard account at modahealth.com and click on Find Care. Enter the network name as Pioneer when a network name is required.

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

To search for Tier 2 providers, go to the First Choice website at https://www.fchn.com/providersearch/moda-ak and search providers in the state of Alaska.

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 for savings on DME:

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

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

SECTION 6. PRIOR AUTHORIZATION

We use prior authorization to make sure your treatments are safe, that services and medications are used the right way, and that cost effective treatment options are used. When a service requires prior authorization, we evaluate it using evidence based criteria that align with medical literature, best practice clinical guidelines and guidance from the FDA. We will authorize medically necessary services, supplies or medications based upon your medical condition. We may encourage you to use a preferred treatment center or provider.

When your professional provider suggests a type of service that requires authorization (see section 6.1.1), ask your provider to contact Moda Health for prior authorization before you receive the service. Emergency hospital admissions must be authorized by your provider within 48 hours after you are admitted (or as soon as reasonably possible). We will send a letter to tell the hospital, professional provider and you whether the services are authorized.

6.1 PRIOR AUTHORIZATION REQUIREMENTS

If you fail 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. You will be responsible for any charges not covered because of noncompliance with authorization requirements.

The prior authorization penalty does not count 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 of the following types of services 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. Diagnostic services, including imaging services
f. Infusion therapy
g. Medications
h. Medically necessary non-emergency services outside of the state of Alaska
i. Non-emergent air ambulance services

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

6.1.2 Prior Authorization Limitations

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

a. An authorization is valid for a set period of time. Authorized services 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 you and your provider. If you are working with a Care Coordinator or Case Manager (see section 2.4), they can help you understand how to access your authorized treatment.

6.1.3 Second Opinion

We may recommend you see another provider for an independent review to confirm that non-emergency treatment is medically necessary. The Plan pays the full cost of the second opinion with any deductible waived.

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

SECTION 7. BENEFIT DESCRIPTION

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

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

Many services must be prior authorized (see Section 6.1). A complete list is available on your Member Dashboard or you may ask Customer Service. If you fail to obtain the required prior authorization, it will result in denial of benefits or a penalty. Services outside of any limitations in the authorization may also be denied.

7.1 WHEN BENEFITS ARE AVAILABLE

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

a. You meet the eligibility provisions of the Plan
b. You have applied for coverage and we have enrolled you on the policy
c. You have paid your 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 you are in a hospital inpatient on the day the policy with the Group ends, the Plan will continue to pay claims for covered services for that hospitalization until you are 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 you 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.

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

7.2 URGENT & EMERGENCY CARE

Emergency services will be covered at the Tier 1 benefit level. Information on how you can send a claim to us when the provider does not send a claim form on your behalf is found in section 9.1.

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 is able to provide the treatment you need. Medically necessary services and supplies provided by the ambulance are also covered. This benefit only covers the member that requires transportation. Tier 3 ground ambulance providers may bill you for charges over the maximum plan allowance.

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

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

7.2.2 Commercial Transportation to Obtain Care

Coverage at the Tier 1 level and limited to one-way air or surface transportation services in the state of Alaska 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 you became ill or injured and end at the location of the nearest hospital equipped to provide treatment not available in a local facility.

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 you if you are under the age of 18 and require 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

You are covered for treatment of emergency medical conditions (as defined in Section 12) worldwide. If you believe you have a medical emergency, you should call 911 or seek care from the nearest appropriate provider.

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

All claims for emergency services (as defined in Section 12) will be paid at the Tier 1 benefit level. Using a Tier 1 or Tier 2 emergency room does not guarantee that all providers working in the emergency room and/or hospital are also Tier 1 or Tier 2 providers. Tier 3 providers cannot balance bill you except when permitted by law.

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 needed for emergency medical screening exams or treatment to stabilize an emergency medical condition.

If your condition requires hospitalization in a Tier 3 facility or a facility outside of Alaska, the treating or attending physician will monitor your condition and determine when you can be safely transferred to a Tier 1 facility. We will stop paying Tier 1 benefits for care at the Tier 3 facility beyond the date the treating or attending physician determines you can be safely transferred.

The Tier 1 benefit level is not available if a member goes to a Tier 3 hospital or a hospital outside of Alaska for care that is not emergency medical care. The following are some examples of services that are not for treatment of emergency medical conditions:

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

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

7.2.5 Urgent Care

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

An urgent care facility is an office or clinic distinct from a hospital emergency room. Its purpose is to diagnose and treat illness or injury for patients without an appointment who are seeking immediate medical attention.

Note: Most walk-in or same-day clinics and immediate care facilities do not bill as urgent care facilities. If you go to one of these facilities, the visit will be covered under the office visit benefit (section 7.4.27). Services will not be paid under the urgent care benefit unless the facility you go to bills as an urgent care facility.

7.3 PREVENTIVE SERVICES

Under the Affordable Care Act (ACA), certain services are covered at no cost to you when performed by a Tier 1 provider. Tier 2 preventive services are also covered at no cost sharing (see Section 3 for benefits paid at the Tier 3 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 (https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf), and women (www.hrsa.gov/womensguidelines/)

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

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

You may call Customer Service to find out 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 have member cost sharing when not prohibited by federal law.

Some commonly used preventive services covered by the Plan are:

7.3.1 Colorectal Cancer Screening

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

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

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

Anesthesia that is determined to be medically necessary by your attending provider for colorectal cancer screening is covered under the preventive benefit. If the anesthesia is determined not medically necessary by your attending provider, it is not covered.

These screening timelines apply to you if you are not at high risk for colorectal cancer. You may be screened earlier or more often if it is medically necessary. If you are at high risk, screening tests and laboratory tests are covered as recommended by your professional provider. You are at high risk if you have 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. Screening exams and laboratory tests, including a follow-up colonoscopy to check progress of the original findings, are paid at the medical benefit level if you do not meet the criteria for the USPSTF A or B rated recommendation.

7.3.2 Contraception

All FDA approved contraceptive methods, including sterilization with counseling, and related office visits, are covered when prescribed by a professional provider. Contraception other than a vasectomy, when delivered by a Tier 1 or Tier 2 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

Routine immunizations are limited to those recommended by the ACIP. Immunizations only for 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:

a. Newborn: One hospital visit
b. Age 2 to 4: 3 exams
c. Age 5 and above: One exam every year

A preventive exam is a scheduled medical evaluation that focuses on preventive care, and is not problem focused. It includes appropriate history, physical examination, review of risk factors with plans to reduce them, and ordering 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. If you are 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 if you are between the ages of 35 and 40 and 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

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

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

7.4 General Treatment Services

All services must be medically necessary. Many outpatient services must be prior authorized. All nonemergency inpatient and residential care must be prior authorized. If you fail to obtain the required prior authorization, it will result in denial of benefits or a penalty. See section 6.1.1 for more information about prior authorization.

7.4.1 Acupuncture

Covered up to an annual visit limit. Other services you may get at an acupuncture appointment 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 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 need to be prior authorized and have specific benefit limitations. You must get specialty anticancer medications from our designated specialty pharmacy (see section 7.6.3). For some anticancer medications, you may have to enroll in programs to help make sure the medication is used correctly and/or lower the cost of the medication. You can find more information on your Member Dashboard or by contacting Customer Service.

7.4.3 Applied Behavior Analysis (ABA)

Applied Behavior Analysis (ABA) 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.

ABA for autism spectrum disorder and the management of care provided in your 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 Behavioral Health

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

Intensive outpatient mental health treatment and TMS must be prior authorized.

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

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

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

A residential program is a 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 to treat behavioral health conditions. Residential program does not include any program that provides less than 4 hours per day of direct treatment services. A residential program or facility must be state-licensed for services to be covered.

Mental Health

These services by a mental health provider are covered:

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
e. Partial hospitalization, inpatient and residential mental health care

Substance Use Disorder Services

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

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

7.4.5 Biofeedback

Services are only covered to treat tension or migraine headaches. Covered visits are subject to a lifetime visit limit.

7.4.6 Clinical Trials

Usual care costs for your care if you are 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 your treating physician determines that there is no clear superior non-investigational 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 non-investigational 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 your 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 you and one caregiver that is primarily for and essential to the medical care

Your 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 only for data collection and analysis and not used in the clinical management
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.

7.4.7 Cochlear Implants

Cochlear implants are covered when medically necessary and prior authorized.

7.4.8 Pediatric Dental Care

Dental care is covered through the end of the month in which you 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 if you are age 12 and over, child prophylaxis if you are 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 7.4.8h)(vi)).

7.4.9 Dental Injury

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

Implants and implant related services are not covered.

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 7.6), when you buy them from a pharmacy with a valid prescription and using a preferred

manufacturer (see the preferred drug list on your Member Dashboard). Insulin pumps may also be covered under the DME benefit (section 7.4.12) if you do not get them from a pharmacy.

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

a. HbA1c lab test
b. Checking for kidney disease
c. Annual dilated eye exam or retinal imaging, including one by an optometrist or ophthalmologist
d. 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

Services must be for treatment of a medical or mental health condition.

Diagnostic services include:

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

Most advanced imaging services must be prior authorized (see section 6.1.1). This includes radiology (such as MR procedures like MRI and MRA, CT, PET and nuclear medicine) and cardiac imaging.

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

7.4.12 Durable Medical Equipment (DME), Supplies & Appliances

Equipment and related supplies, including sales tax, that help you manage a medical condition. DME is typically for home use and is designed for 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 do day to day activities or essential job-related activities. If you can get the correction or support you need by modifying a mass-produced shoe, then we will only cover the cost of the modification. 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 you get them from a pharmacy. You must have a prescription and use a preferred manufacturer (see section 7.6 for coverage under Pharmacy benefit.)

We cover the rental charge for DME. For most DME, the rental charge is covered up to the purchase price. You can work with your providers to order your prescribed DME.
You may contact Customer Service for help finding a Tier 1 DME provider.

We encourage you to use a preferred DME provider. You may save money when you do. You can find a preferred provider using Find Care on your Member Dashboard (see section 5.2.2). Change your recurring prescription or automated billing to a preferred DME provider by contacting your current provider and the preferred DME provider and asking for the change.

All supplies, appliances and DME must be medically necessary. 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 you may ask 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 way that voids its warranty. If we ask you to, you must authorize anyone supplying your DME to give us information about the equipment order and any other records we need to approve a claim payment.

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

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

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

7.4.14 Gender Affirming Services
Expenses for gender affirming treatment are covered when you meet the following conditions:

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

Covered services may include:

a. Mental health
b. Hormone therapy (including puberty suppression therapy for adolescents)
c. Surgical procedures (see section 7.4.36):
    i. Breast/chest surgery
    ii. Gonadectomy (hysterectomy/oophorectomy or orchiectomy)
    iii. Reconstruction of the genitalia
    iv. Gender affirming facial surgery

7.4.15 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.

7.4.16 Home Healthcare

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

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

a. Registered or licensed practical nurse
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 section 7.4.12 and section 7.4.17.

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.

7.4.17 Hospice Care

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

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

The hospice treatment plan is a written plan of care established and periodically reviewed by your attending physician. The physician must certify in the plan that you are 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 when you are terminally ill and not getting any more treatment to cure your terminal illness.

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

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

Hospice Inpatient Care
Short-term hospice inpatient services and supplies for a limited number of days are covered.

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

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

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

7.4.18 Hospital Care

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

a. **Hospital room.**
b. **Isolation care.** When it is medically necessary, based on generally recognized medical standards, to protect you from contracting the illness of another person or to protect other patients from contracting your illness
c. **Intensive care unit.**
d. **Facility charges** for surgery performed in a hospital outpatient department
e. **Other hospital services and supplies** when medically necessary for treatment and ordinarily provided by a hospital
f. **Take-home prescription drugs** are limited to a 3-day supply at the same benefit level as hospitalization

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

a. Under age 7
b. Physically or developmentally disabled
c. With a medical condition that would place you at undue risk if the dental procedure were performed in a dental office

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

7.4.19 Hospital Visits

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

7.4.20 Infusion Therapy

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

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

Your professional provider must get prior authorization for infusion therapy. You 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 you save money. See section 7.6.4 for self-administered infusion therapy. Some services and supplies are not covered if they are billed separately. They are considered included in the cost of other billed charges.

7.4.21 Kidney Dialysis

Covered expenses include:

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

If you have end-stage renal disease (ESRD), you must be enrolled in Medicare Part B to receive the best benefit.

7.4.22 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.

7.4.23 Medical Travel Support

We cover some surgical procedures at the cost share in Section 3 when they are provided at a preferred facility, which may include:

Through Surgery Care

a. orthopedic
b. cardiac
c. vascular
d. general surgery
e. spine
f. neurologic
g. women's health

If you have upcoming medical procedures, you can call us at 888-387-3909 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, you can select a preferred provider and facility. The Care Coordinator will then coordinate with your providers in both locations to set up the treatment plan.

We also cover coach airfare, ground transportation and lodging necessary for you and one companion for traveling to get care. If you are eligible for care in a preferred facility, you 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 you follow the travel arrangement we made, we cover the travel expenses and there is no cost to you. 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 us but you decided not to proceed with the medical procedure for reasons other than medical necessity, you are responsible for the entire cost of the unused airfare, ground transportation and lodging expenses.

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

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

You 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 you save money. Find a preferred provider by asking Pharmacy Customer Service.

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

7.4.25 Nonprescription Enteral Formula for Home Use

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

7.4.26 Nutritional Therapy

Dietary or nutritional therapy includes:

a. Assessment of your overall nutritional status
b. Individualized diet and nutritional counseling

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

a. If you have a body mass index (BMI) of 30 kg/m^2 or higher
b. If you are overweight or obese and have cardiovascular disease risk factors
c. For children age 6 years and older who are overweight or obese
d. If you are female and age 40 to 60 with normal or overweight BMI, to maintain weight or limit weight gain

Also see diabetes services (section 7.4.10). Nutritional therapy does not include medical foods or nutritional supplements.

7.4.27 Office or Home Visits

A visit means you are actually examined by a professional provider. Covered expenses include consultations with written reports, and second opinion surgery consultations. Office visits by naturopathic physicians are specialist office visits unless we have credentialed the naturopathic physician as a primary care provider.

We will pay the covered expenses of the first 3 PCP home and office visits and virtual care visits per year at $5 if the service is performed by a Tier 1 provider. Subsequent visits will be subject to the standard cost sharing. If any of the visits is performed by a Tier 2 or Tier 3 provider, we will pay at the regular Tier 2 or Tier 3 reimbursement rate.

The benefit must be by Tier 1 providers of the following types:

a. General practitioners
b. Family practitioners
c. Internal medicine practitioners
d. Pediatricians
e. Nurse practitioners
f. OB/GYN practitioners
g. Physician assistant practitioners
h. Naturopathic practitioners credentialed as a PCP
i. Geriatric practitioners

7.4.28 Phenylketonuria

We cover the formulas necessary for the treatment of phenylketonuria.

7.4.29 Podiatry Services

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

7.4.30 Pre-admission Testing

Preadmission testing is covered when ordered by a professional provider.

7.4.31 Psychological or Neuropsychological Testing and Evaluation

Covered services include interpretation and report preparation that are necessary to prescribe an appropriate treatment plan.

7.4.32 Inpatient 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.

If you are under age 7, or with autism spectrum disorders, neurodevelopmental therapy to restore and improve function and maintenance therapy to prevent significant deterioration in your condition or function are covered.

7.4.33 Outpatient 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.

If you are under age 7, or with autism spectrum disorders, neurodevelopmental therapy to restore and improve function and maintenance therapy to prevent significant deterioration in your 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 your 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.

7.4.34 Skilled Nursing Facility Care

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

A limited number of days are covered as shown in Section 3. Covered expenses are limited to the daily service rate for a semi-private hospital room.

Exclusions
These skilled nursing facility charges are not covered:

a. If you were admitted before you were enrolled in the Plan
b. If the care is mainly for:
    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

7.4.35 Spinal & Other Manipulations

Covered up to an annual visit limit for treatment of a medical condition. Other services you may get at a spinal manipulation visit, 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 specialist office visits. Spinal manipulation services must be prior authorized.

7.4.36 Surgery

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

The surgery cost sharing also applies to these services:

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

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.

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

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

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

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

Surgery for breast enhancement, making breasts match, and replacing breast implants to change the shape or size of your breasts is not covered except to treat gender dysphoria (see section 7.4.14) or after a mastectomy.

Reconstructive surgery after a medically necessary mastectomy includes:

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

Treatment for complications related to a reconstructive surgery is covered when medically necessary. Treatment for complications related to a cosmetic surgery is not covered.

7.4.37 Therapeutic Injections

Administrative services for therapeutic injections, such as allergy shots, are covered when you get them in a professional provider's office. When you can get results 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 7.4.24 and 7.6.4.

7.4.38 Therapeutic Radiology

Covered expenses include:

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

7.4.39 Transplants

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

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

We cover medically necessary transplants that follow standard medical practice and are not experimental or investigational. Prior authorization should be obtained as soon as possible after you have been identified as a possible transplant candidate. To be valid, prior authorization approval must be in writing from Moda Health. This section's requirements do not apply to corneal transplants and collecting and/or transfusing blood or blood products (see section 7.4.36).

Benefits for transplants are limited as follows:

a. Transplant procedures must be done at a Center of Excellence. If a Center of Excellence cannot provide the necessary type of transplant, Moda Health will prior authorize services at another transplant facility
b. Donor costs are covered as follows:
    i. If you are the recipient or self-donor, donor costs related to a covered transplant are covered
    ii. If you are the donor and the recipient is not enrolled on the policy, we will not pay any benefits toward donor costs

iii. If the donor is not enrolled in this Plan, expenses that result from complications and unforeseen effects of the donation are not covered
iv. Donor costs paid under any other health coverage are not covered by the Plan.

c. 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 lives more than 50 miles from the Center of Excellence unless the medical condition requires treatment at a closer transplant facility.
d. Professional provider transplant services are paid according to the benefits for professional providers
e. Immunosuppressive drugs you get during a hospital stay are paid as a medical supply. Outpatient oral and self-injectable prescription medications for transplant related services are paid under the Pharmacy Prescription benefit (section 7.6)
f. We will not pay for chemotherapy with autologous or homogenic/allogenic bone marrow transplant for treatment of any type of cancer not approved for coverage

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

7.4.40 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 you and your provider at different locations.

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 or referred 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. You do not have to pay anything for virtual care visits using the preferred vendor (see Section 3).

7.5 MATERNITY CARE

Pregnancy care, childbirth and related conditions are covered when you get the care from 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 you change providers during pregnancy, maternity services are generally no longer billed as a global charge.

If you have a home birth, the only expenses that are covered are the medically necessary supplies and fees billed by a professional provider. Other home birth charges, such as travel and portable hot tubs, are not covered. Supportive services, such as physical, emotional and information

support to you before, during and after birth and during the postpartum period, are not covered expenses.

7.5.1 Abortion
Elective abortions are covered.

7.5.2 Breastfeeding Support
Comprehensive lactation support and counseling is covered during pregnancy and/or the breastfeeding period. We cover the purchase or rental charge (not to exceed the purchase price) for a breast pump and supplies. The maximum plan allowance (MPA) applies when you buy the pump from a retail store. Charges for extra ice packs or coolers are not covered. Hospital grade pumps are covered when medically necessary.

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

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

7.5.5 Office, Home or Hospital Visits
A visit means you are actually examined by a professional provider.

7.5.6 Hospital Benefits
Covered hospital maternity care expenses are:

a. **Hospital room**
b. **Facility charges** from a covered facility, including a birthing center
c. **Other hospital services and supplies** when medically necessary for treatment and ordinarily provided by a hospital
d. **Nursery care** includes one in-nursery well-newborn infant preventive health exam. You will not have to pay anything when performed by a Tier 1 or Tier 2 provider. Additional visits are covered at the hospital visit benefit level. There is no deductible for routine nursery care. Nursery care is covered under the newborn's own coverage, and is routine while you are confined in the hospital and receiving maternity benefits.
e. **Take-home prescription drugs** are limited to a 3-day supply at the same benefit level as for hospitalization.

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

7.6 Pharmacy Prescription Benefit

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

7.6.1 Covered Medication Supply

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

a. A prescription medication that is medically necessary to treat of a medical condition
b. Compounded medications that have at least one covered medication as the main ingredient
c. Insulin and diabetic supplies including insulin syringes, needles and lancets, test strips, glucometers and continuous glucose monitors. You must have a prescription and use a preferred manufacturer
d. Medications to treat tobacco dependence, including OTC nicotine patches, gum or lozenges as required under the Affordable Care Act. You must have a prescription and use an in-network retail pharmacy to receive the no cost share benefit
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 (such as 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 need to be prior authorized (see section 6.1.1). You must get specialty medications and some other tier medications from a Moda-designated specialty pharmacy.

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

You can ask for a medication that is not on the formulary by having your professional provider submit an exception request or by contacting Customer Service. Formulary exceptions must be based on medical necessity. We will need your prescribing professional provider's contact information and information from your provider to support the medical necessity, including all of the following:

a. You tried the formulary medications using the right dose and for a long enough time, and they did not work for you
b. You were not able to tolerate the formulary medications, or they were not effective for you
c. The formulary medications are expected to be harmful to you or not provide equivalent results to the medication you are asking for
d. The medication treatment you are asking for is not experimental or investigational

We will contact the prescribing professional provider to find out how the medication is being used in your treatment plan. We will make a decision about your exception request within 72 hours – or just 24 hours if your request is urgent. This formulary exception process is not used for a medication or pharmacy charge that is not covered for other reasons, such as plan limitations or exclusions.

7.6.2 Mail Order Pharmacy

You can choose to fill prescriptions for covered medications through a Moda-designated mail order pharmacy. Get a mail order pharmacy form on your Member Dashboard or by asking Customer Service.

7.6.3 Specialty Services & Pharmacy

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

Most specialty medications must be prior authorized. If you do not buy specialty medications at the Moda-designated specialty pharmacy, the expense will not be covered. In the event a specialty medication is not available when you need it and a delay in receiving the medication would threaten the efficacy of treatment or your life, we will prior authorize the medication to be filled locally. For assistance, contact Customer Service.

Some specialty prescriptions may be limited to less than 30 days. Some medications may be eligible for a 90-day supply. For some specialty medications, you may have to enroll in a program to make sure you know how to use the medication correctly and/or to lower the cost of the medication. Get more information on your Member Dashboard or by asking Customer Service.

7.6.4 Self-Administered Medication

All self-administered medications follow all of the prescription medication requirements of section 7.6. Self-administered specialty medications are subject to the same requirements as other specialty medications (section 7.6.3).

Self-administered injectable medications are not covered if you get them in a provider's office, clinic or facility.

7.6.5 Step Therapy

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

If you need assistance with step therapy exceptions, contact Customer Service.

7.6.6 Limitations

a. New FDA approved medications will be reviewed. We may have coverage requirements or limits. You or your prescriber can ask for a medical necessity evaluation if we do not cover a newly approved medication during the review period.
b. We may prior authorize certain brand medications for a specific amount of time or until a generic medication becomes available, whichever comes first. When a generic medication becomes available during the authorized period, the brand medication is no longer covered. You can get the generic medication without a new prescription or authorization.
c. You may not bypass the Plan's requirements (such as step therapy, prior authorization) by starting treatment with a medication, whether by using free samples or otherwise.

d. 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.
e. Medications with dosing intervals greater than the Plan's maximum day supply will have an increased copayment to match the day supply.
f. Medications you buy outside the United States and its territories are only covered in emergency and urgent care situations.
g. You may ask to have your medications refilled early if you are going to travel outside of the United States. When we allow an early refill, it is limited to once every 6 months. You cannot get an early refill to extend your medication supply beyond the end of the plan year.

7.6.7 Exclusions

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

a. **Devices.** Including, but not limited to therapeutic devices and appliances. Information for contraceptive devices is in section 7.6.1 and for other devices in section 7.4.12
b. **Foreign Medication Claims.** Medications you purchase from non-U.S. mail order or online pharmacies or U.S. mail or online pharmacies acting as agents of non-U.S. pharmacies.
c. **Hair Growth Medications.**
d. **Immunization Agents for Travel.** Except as required under the Affordable Care Act.
e. **Institutional Medications.** To be taken by or administered while you are a patient in a hospital, rest home, skilled nursing facility, extended care facility, nursing home, or similar institution.
f. **Medication Administration.** A charge to administer or inject a medication, except for immunizations at 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 that have an OTC option (see the preferred drug list on your Member Dashboard), except for those treating tobacco dependence.
m. **Pharmacies Excluded from the Network.** Medications from pharmacies that have been excluded from the network for non-compliance with fraud, waste and abuse laws.
n. **Repackaged Medications.**
o. **Replacement Medications and/or Supplies.**
p. **Vitamins and Minerals.** Except as required by law.
q. **Weight Loss Medications.**

7.6.8 Definitions

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

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

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

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

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

Preferred Tier Medications are medications, including specialty preferred medication, that we have reviewed and found to be safe and effective at a better price compared to other medications in the same therapeutic class and/or category. Generic medications that have not been shown to be safer or more effective than other more cost effective generic medications are included in this tier.

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

The list may change and will be updated from time to time. Use the prescription price check tool on your Member Dashboard to get the latest information. Ask Customer Service if you have any questions.

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

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

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

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

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

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

7.7 VISION CARE BENEFIT

7.7.1 Pediatric Vision Services

We cover the following services every year through the end of the month in which you 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

You can visit www.vsp.com or call 800-877-7195 to choose a Tier 1 or Tier 2 vision care provider and arrange for vision services. Some vision services may need to be prior authorized.

If you are eligible for vision plan benefits, VSP will provide benefit authorization directly to the Tier 1 or Tier 2 doctor. When contacting a Tier 1 or Tier 2 doctor directly, you must identify yourself as a VSP member so the doctor will obtain benefit authorization from VSP. If you receive services from a Tier 1 or Tier 2 doctor without a benefit authorization or obtain services from a provider who is not a Tier 1 or Tier 2 doctor, you 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 a Tier 3 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

7.7.2 Adult Vision Services

We pay for vision examinations and corrective lenses and frames if you are age 19 and older. You can visit www.vsp.com or call 800-877-7195 to choose a Tier 1 or Tier 2 vision care provider and arrange for vision services. Some vision services may need to be prior authorized.

If you are eligible for vision plan benefits, VSP will provide benefit authorization directly to the Tier 1 or Tier 2 doctor. When contacting a Tier 1 or Tier 2 doctor directly, you must identify yourself as a VSP member so the doctor will obtain benefit authorization from VSP. If you receive services from a Tier 1 or Tier 2 doctor without such benefit authorization or obtain services from a provider who is not a Tier 1 or Tier 2 doctor, you 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 a Tier 3 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 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 if you 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

7.8 Hearing Services Benefit

We cover 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. You must be examined by a licensed physician before obtaining a hearing aid. To qualify for this benefit, you must purchase a hearing aid device. We cover 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, you can call 866-202-2178 to choose a Tier 1 audiologist and arrange for a hearing exam. The audiologist will assist you with choices of hearing aids through a Tier 1 hearing instrument provider. The hearing services vendor has a selection of hearing aids available to you.

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

This section lists Plan exclusions. These are in addition to the limitations and exclusions that are described in other sections. These services, supplies and conditions are not covered, even if they are medically necessary, are recommended or provided by a professional provider, or if they relate to a covered condition. Treatment of a complication or consequence that happens because of an exclusion is not covered.

Animal Therapy

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

Care Outside the United States
Except for care that is due to an urgent or emergency medical condition

Charges Over the Maximum Plan Allowance

Correctional Services
Including education-only, court ordered anger management classes

Cosmetic Procedures
Any procedure or medication with the main purpose of changing or maintaining your appearance and that will not result in significant improvement in body function. Examples include rhinoplasty, breast enhancement, liposuction, and hair removal. Reconstructive or gender affirming surgery is covered if medically necessary and not specifically excluded (see section 7.4.14 and mastectomy, section 7.4.36)

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

Dental Examinations and Treatment; Orthodontia
Except services described in sections 7.4.8 and 7.4.9

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

a. Books, tapes, pamphlets, subscriptions, videos and computer programs (software)
b. Level 0.5 education-only programs

Experimental or Investigational Procedures and Medications
Expenses due to experimental or investigational procedures or medications. Includes related expenses, even if they are covered in other (non-experimental, non-investigational) situations (see definition of experimental/investigational in Section 12)

Faith Healing

Food Services
Including Meals on Wheels and similar programs and 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

Homeopathic Treatment and Supplies

Illegal Acts
Services and supplies to treat an injury or condition caused by or arising directly from your 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 you get 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

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

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

Non-Therapeutic Counseling
Including legal, financial, occupational and religious counseling

Obesity or Weight Reduction
Even if you are morbidly obese. 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 change your 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

We cover services and supplies that are necessary to treat established medical conditions that may be caused by or made worse by obesity. 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 described in section 7.4.12

Orthognathic Surgery
Including associated services and supplies

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

Personality Disorders

Physical Exercise Programs
Programs, videos and exercise equipment

Private Nursing Services

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

Reports and Records
Including charges for completing claim forms or treatment plans

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

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

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

Self-Improvement Programs
Psychological or lifestyle improvement programs including self-help programs, educational programs, retreats, assertiveness training, marathon group therapy, and sensitivity training, except as covered under section 7.4.15

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

Services for Administrative or Qualification Purposes
Physical or mental examinations, psychological testing and evaluations and related services for purposes such as employment or licensing, participating in sports or other activities, insurance coverage, or deciding legal rights, administrative awards or benefits, corrections or social service placement**.**

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

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

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

This exclusion does not apply to the Veterans' Administration of the United States if the care is not service related.

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

Services Provided by Volunteer Workers

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

Support Groups
Including voluntary mutual support groups, such as Alcoholics Anonymous and family education or support groups except as required under the Affordable Care Act

Taxes, Fees and Interest
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 7.4.13 and virtual care visits (telehealth) covered in section 7.4.40

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

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

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

Treatment After Coverage Ends
The only exception is if you are 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 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 who do not have illness or a diagnosed behavioral health condition, or treatment of normal transitional response to stress

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 your condition
c. Not established as the standard treatment by the medical community in the service area where you receive them
d. Primarily for your convenience or that of a provider
e. Not the least costly of the alternative supplies or levels of service that can be safely provided to you

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

Vision Care
Except as otherwise covered 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 7.7.1 for pediatric vision services and section 7.4.10 for coverage of annual dilated eye exam to manage diabetes

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

Vitamins and Minerals
Not covered unless required by law or if medically necessary to treat a specific medical condition. Coverage is only under the medical benefit. The vitamin or mineral must 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 you get because of your 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 if you are an owner, partner or executive officer, if you are exempt from workers' compensation laws and the Group does not provide workers' compensation coverage to you.

SECTION 9. CLAIMS ADMINISTRATION & PAYMENT

9.1 SUBMISSION & PAYMENT OF CLAIMS

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.

We do not always pay claims in the order in which charges are incurred. This may affect how your cost sharing is applied to claims. For example, a deductible may not be applied to the first date you are seen in a benefit year if a later date of service is paid first.

We may pay benefits to you, the provider or to both jointly.

9.1.1 How to Send Us Claims

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

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

Include all of the following information:

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

Some claims will require additional information:

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

We will reimburse any covered expenses.

9.1.2 Prescription Medication Claims

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

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

9.1.3 Vision Services Claims

If you have vision services provided by a Tier 3 provider or a Tier 1 or Tier 2 provider without benefit authorization, you will need to submit a request for reimbursement by completing the member reimbursement claim form. It is available by visiting www.vsp.com or calling 800-877-7195.

9.1.4 Explanation of Benefits (EOB)

We will tell you how we processed a claim in a document called an Explanation of Benefits (EOB). If all or part of a claim is denied, we will tell you why in the EOB. We encourage you to access your EOBs electronically by signing up through your Member Dashboard.

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

9.1.5 Claim Inquiries

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

9.1.6 Time Frames for Processing Claims

For claims that do not require additional information, we will pay or deny the claim, and an EOB will be sent to you within 30 days after receiving the claim.

If more information is needed to process the claim for reasons beyond our control, a notice will be sent to you explaining what information is needed within 30 days after we receive the claim. The party responsible for providing the additional information will have 45 days to submit it. We will then finish processing the claim and send an EOB to you 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 9.1.

9.1.7 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.

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.

9.2 COMPLAINTS, APPEALS & EXTERNAL REVIEW

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

9.2.1 Time Limit for Submitting Appeals

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

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

You can fill out an appeal form (in your Member Dashboard under Resources), or send us a letter including all of the identifying information from the appeal form (see "If I am not satisfied…" in section 13.2). Describe what happened and what outcome you are hoping for. Include medical records or other documentation that will help us investigate your appeal.

You may ask for extra time to file your appeal. Your request must be in writing, and must include at least one reason that you need the extension, with a fair and reasonable basis for us to allow it.

9.2.2 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 you are not satisfied with the outcome of the first level appeal, and the dispute meets the specifications outlined in section 9.2.4, you 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 we agree otherwise. We will provide 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 us in connection with the claim, it will be provided to you, in advance and free of charge, before any final internal adverse benefit determination. You may respond to this information before our determination is finalized.

The timelines addressed in the sections below do not apply when you do 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.

You may review the claim file and submit written comments, documents, records and other information to support your appeal. You may choose a person (representative) to act on your behalf.

9.2.3 First Level Appeals

You must submit an appeal in writing. For claims involving urgent care, the appeal may be made by phone. If necessary, Customer Service can help with filing an appeal. We 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. Review of appeals that meet the criteria to be expedited will be finished within 72 hours in total for the first and second level appeals combined after we have received those appeals. The time between the first level appeal decision and when we receive the second level appeal does not count.

If you do not provide enough information for us to make a decision at each appeal level, we will notify you within 24 hours of receiving the appeal of the specific information necessary to make a decision. You 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, we will send a written notice of the decision to you, 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.

9.2.4 Second Level Appeals

If you disagree with the decision regarding the first level appeal of a utilization review issue, you 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 our 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. We will notify you 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 you elect 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 you choose not to pursue the second level appeal, we waive any right to assert that you failed to exhaust the internal review process should you elect to file a lawsuit in court under ERISA Section 502(a) following the first level appeal.

9.2.5 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, we will notify you in advance and provide information about the right to appeal. We will continue to provide coverage while we review your appeal. If the decision is upheld, you are responsible for the cost not covered by us.

The first step of review must be exhausted before you can exercise the right to file a lawsuit in court under ERISA Section 502(a), unless we fail 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 you have not used all of your internal appeal rights, which is generally required before filing a lawsuit.

9.2.6 External Review

If the dispute meets the criteria below, you may ask to have it reviewed by an independent review organization (IRO) appointed by the Alaska Division of Insurance.

a. You 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 we do not 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. You may submit additional information to the IRO within 5 business days, or 24 hours for an expedited review. You 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. You must have finished the appeal process described in sections 9.2.3 and 9.2.4. However, we may waive this requirement and have an appeal referred directly to external review with your consent.
e. You shall provide complete and accurate information to the IRO in a timely manner.

We will send a written notice to you 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, we will send a written notice to you within 24 hours. Otherwise, the IRO will expedite the review and provide notice within 72 hours after they receive the request.

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

9.2.7 Complaints

Submit your complaint in writing within 180 days from the date of the claim. We will review complaints about:

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 us

We will finish reviewing your complaint within 30 days. If we need more time, we will notify you about the delay. We will have 15 more days to make a decision.

9.2.8 Additional Member Rights

You 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

9.2.9 Definitions

For purposes of section 9.2, the following definitions apply:

Adverse Benefit Determination is a written notice from us 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 we have upheld at the end of the internal appeal process. The internal appeal process is finished.

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

Appointed or Authorized Representative is a person appointed or authorized to represent you in filing an appeal or complaint. You 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 your behalf (court-appointed guardian, one with Durable Power of Attorney, healthcare proxy, or person designated under a healthcare consent statute).

Claim Involving Urgent Care is 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 risk your life or health or ability to regain maximum function
b. Would subject you to severe pain that cannot be adequately managed without the requested care or treatment. A professional provider with knowledge of your medical condition decides this.

Urgent care claims include requests involving a denial of coverage based on a determination that treatment was experimental or investigational. Your 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 is an expression of dissatisfaction to us 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 is any claim for a benefit under the Plan for care or services that you have already received.

Pre-service claim is any claim for a benefit under the Plan for care or services that must be prior authorized and you have not had the services yet.

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

a. The care is not medically necessary or appropriate

b. The care is investigational or experimental
c. The decision about whether a benefit is covered involved a medical judgment

9.3 CONTINUITY OF CARE

If you are being actively treated by a Tier 1 or Tier 2 provider at the time the professional provider or facility's written agreement ends, you may continue to be treated by that provider for a limited period of time. During this time, we will consider the provider to still have an agreement only while the Plan remains in effect and

1. Regarding continuity of care with a professional provider
   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 you are pregnant on the date of termination; or
   b. until the end of the medically necessary treatment for the medical condition if you have a terminal medical condition. In this paragraph, "terminal" means a life expectancy of less than one year.

2. Regarding continuity of care with a facility

For the period that ends on the earlier of the following dates:
a. 90 days starting on the date we send you a letter about your right to continuity of care
b. the date on which you are no longer a continuing care patient with the provider

Continuing care patients means persons who are at least one of the following:
a. Undergoing treatment from the provider for a serious and complex condition, defined as:
   i. In the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm.
   ii. In the case of a chronic illness or condition, a condition that is:
      - Life-threatening, degenerative, potentially disabling, or congenital and
      - Requires specialized medical care over a prolonged period of time
b. Undergoing a course of institutional or inpatient care from the provide
c. Scheduled to undergo nonelective surgery from the provider including receipt of postoperative care from such provider or facility with respect to such a surgery
d. Pregnant and undergoing treatment for pregnancy from the provider
e. Terminally ill and receiving treatment for such illness from the provider

9.4 BENEFITS AVAILABLE FROM OTHER SOURCES

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

9.4.1 Coordination of Benefits (COB)

Coordination of benefits applies when you have healthcare coverage under more than one plan.

If you are covered by another plan or plans, the benefits under this Plan and the other plan(s) will be coordinated. This means one plan pays its full benefits first, and then any other plans pay. The order of benefit determination rules decide the order in which each plan will pay a claim for benefits. (For coordination with Medicare, see section 9.4.2.)

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

9.4.1.1 When this Plan Pays First
This Plan is primary and will pay first if the claim is for:

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

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

9.4.1.2 How COB Works

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

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

a. We will calculate the benefits we would have paid if you did not have any other healthcare coverage. We will apply that amount to any allowable expense that the primary plan did not pay.
b. We will reduce the benefits we pay so that payments from all plans are not more than 100% of the total allowable expense
c. If the primary plan did not cover an expense because you did not follow that plan's rules, we will not cover that expense either.

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

9.4.1.3 Definitions
For purposes of section 9.4.1, the following definitions apply:

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

a. Group or individual insurance contracts and group-type contracts
b. HMO (health maintenance organization) coverage
c. Coverage under a labor-management 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

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

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

Plan does not include:
a. Hospital indemnity coverage or other fixed indemnity coverage
b. Accident-only or school accident coverage
c. Specified disease or specified accident coverage
d. Benefits for non-medical components of group or individual long-term care policies
e. Medicare supplement policies
f. Medicaid policies
g. Coverage under other federal governmental plans, unless permitted by law

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

These are not allowable expenses:
Any expense that is not covered by any plan covering you. Any expense a provider is not allowed to charge you.

9.4.2 Coordination with Medicare

The Plan coordinates benefits with Medicare as required under federal law. This includes coordinating to the Medicare allowable amount.

Members who have end-stage renal disease (ESRD) should enroll in Medicare as soon as they are eligible.

9.4.3 Third Party Liability

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

The Plan does not cover benefits when someone else - a third party - is legally responsible. This may include a person, company or an insurer. Recovery from a third party may be difficult and take a long time, so we will pay your covered expenses based on the understanding and agreement that we are entitled to be reimbursed in full for any benefits we paid that are or may be recoverable from a third party or other source, no matter how the recovery is characterized.

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

a. If we pay any claims that are, or are alleged to be, the responsibility of a third party, you hold any rights of recovery against the third party in trust for us.

b. We are entitled to be reimbursed for any benefits the Plan pays out of any recovery from a third party if there is a settlement or judgment against the third party. This is true whether or not the third party admits liability or claims that you are also at fault. We are entitled to receive the amount of benefits the Plan has paid whether the healthcare expenses are itemized or expressly excluded in the third party recovery.

c. If this Plan is subject to ERISA, it is not responsible for and will not pay any fees or costs (such as attorney fees) associated with your pursuing a claim against a third party. Neither the "made-whole" rule nor the "common-fund doctrine" rule applies. If the Plan is exempt from ERISA, a proportionate share of reasonable attorney fees may be subtracted from our recovery.

d. Even without your written authorization, we may release to, or obtain from, any other insurer, organization or person, any information we need to carry out the provisions of section 9.4.3.

e. If it is reasonable to expect that you will have future expenses for which the Plan might pay benefits, you will seek recovery of such future expenses in any third party claim.

f. Section 9.4.3 applies to you if the Plan advances benefits whether or not the event causing your injuries occurred before you became covered by Moda Health.

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

9.4.4 Surrogacy

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

SECTION 10. ELIGIBILITY & ENROLLMENT

For coverage to become effective, you must submit an application on time. Any necessary premiums must also be paid.

10.1 SUBSCRIBER

You must give the Group a complete and signed application for yourself and any dependents to be enrolled within 31 days of becoming eligible to apply for coverage.

Your coverage begins on the date specified in the policy. This will be on your enrollment date or after a waiting period. To stay covered by the Plan, you must work the required hours. If your job changes, this could affect your eligibility.

You are eligible to enroll in the Plan if you live within the Municipality of Anchorage, Fairbanks North Star, Haines, Kenai Peninsula, Ketchikan Gateway, Matanuska-Susitna, Petersburg and Municipality of Skagway boroughs, City and Borough of Juneau, City and Borough of Sitka, City and Borough of Wrangell, Hoonah-Angoon Census Area and Prince of Wales-Hyder Census Area service area.

You must tell us and the Group if your address changes.

10.2 DEPENDENTS

A subscriber's legal spouse is eligible for coverage. If a subscriber marries, the spouse and their children can enroll as of the date of the marriage. Coverage begins on the first day of the month after your application is received. See section 10.2.1 for more information.

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. The age limit applies even if a court or administrative order requires you to provide coverage after age 26.

In this Plan, eligible children are:

a. The biological or adopted child of the subscriber or the subscriber's eligible spouse
b. Children placed for adoption with the subscriber.
c. A newborn child of an enrolled dependent
d. Children related to a subscriber and the subscriber is their legal guardian.

Your newborn child is eligible from birth and coverage begins that day. A subscriber's adopted child or child placed for adoption is eligible on the date of placement. Their coverage begins on the date of adoption or placement. Court ordered coverage begins on the first day of the month after the date that the Group determines that the order qualifies as a QMCSO, and that the child is eligible to enroll in the Plan. You must provide proof of legal guardianship to cover the subscriber's grandchild after the first 31 days from birth if the grandchild's parent is not an enrolled dependent under the Plan. See section 10.4 to add your new child.

A subscriber's child who has a disability that makes them physically or mentally incapable of self-support may be eligible for coverage even when they are over 26 years old. To be eligible, the child must be unmarried and mainly 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. We will determine eligibility based on commonly accepted guidelines. To make sure there is no gap in coverage, we need the following information 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

We will make an eligibility determination based on documentation of the child's medical condition. We will review eligibility from time to time unless the disability is certified to be permanent.

10.2.1 New Dependents

A new dependent may cause your premium to go up. Any premium changes will apply from the date coverage is effective. If you do not submit an application and/or payment when required, the new dependent will not be covered (coverage for a new child will end 31 days after birth or adoption).

To add a new dependent to your coverage, submit:

a. Complete and signed application
b. Documentation. This may be a marriage certificate, birth certificate, or guardianship, adoption or placement for adoption paperwork

You must apply within 31 days of the new dependent becoming eligible. You need to inform us if you are adding or dropping family members from your coverage, even if it does not change your premiums

10.3 OPEN ENROLLMENT

If you are not enrolled within 31 days of first becoming eligible, you must wait for the next open enrollment period to enroll unless:

a. You qualify for special enrollment as described in section 10.4
b. A court has ordered you to provide coverage for a spouse or minor child under a subscriber's health benefit plan. You must enroll no more than 30 days after the court order is issued
c. Your 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. If you enroll during open enrollment, coverage begins on the date the Plan renews.

10.4 SPECIAL ENROLLMENT

If you lose other coverage or become eligible for a premium assistance subsidy, you have special enrollment rights. Special enrollment applies
to both the eligible employee and their dependent if neither is enrolled in the Plan and either loses other coverage or becomes eligible for a premium assistance subsidy.

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

10.4.1 Loss of Other Coverage

If you do not enroll in the Plan when you are first eligible or at open enrollment because you have other health coverage, you may be able to enroll outside of the open enrollment period. You must meet all of the following criteria:

a. You stated in writing that you already had health insurance coverage when the Plan was first offered to you
b. You ask to enroll no more than 31 days after your prior coverage ended (except for event iv. below, which allows up to 60 days)
c. One of the following events has occurred:
    i. Your prior coverage was under a COBRA continuation provision and the coverage under such provision was exhausted
    ii. Your 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. loss of dependent status per plan terms, including divorce or legal separation
        B. death
        C. end of employment or not working enough hours
        D. the plan stops offering coverage to a group of similarly situated persons
        E. moving out of an HMO service area and the plan does not have another option
        F. the benefit package option is canceled, and no substitute option is offered
    iii. You were covered under Medicaid or a children's health insurance program (CHIP) and the coverage ended due to loss of eligibility. You have up to 60 days after the end of coverage to enroll.

10.4.2 Payment Changes

You may have special enrollment rights when there are changes to how your premiums are paid:

a. Employer contributions toward your other active coverage (not COBRA) end. You must ask for special enrollment no more than 31 days after the contributions 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.)
b. If you are covered under Medicaid or CHIP and become eligible for a premium assistance subsidy, you may enroll in the Plan outside of the open enrollment period. You must ask for special enrollment no more than 60 days after becoming eligible.

Coverage begins on the first day of the month after the special enrollment request is received, or coinciding with, but not before, the premium contribution or subsidy change.

10.4.3 Gaining New Dependents

The employee has special enrollment rights if they are not enrolled at the time of the event that caused them to gain a new dependent (such as marriage, birth, adoption, or placement for adoption) You can enroll along with your new dependent. See section 10.2.1.

10.4.4 Qualified Medical Child Support Order (QMCSO)

The child of an eligible employee may have a right to enroll because of a qualified medical child support order (QMCSO). You may get a copy of the detailed procedures used to decide if an order qualifies as a QMCSO from the Group at no cost. Coverage begins on the first day of the month after the date the Group decides the order qualifies as a QMCSO and that the child is eligible to enroll in the Plan.

10.5 When Coverage Ends

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

10.5.1 The Group Plan Ends

Coverage ends for the Group as a whole and members on the date the Plan ends except for the extended benefits stated in section 7.1. This may happen because the Group chooses to end the Plan, or we may end the policy for fraud or intentional misrepresentation of material fact by the Group or if the Group does not follow the requirements of the policy.

10.5.2 Subscriber Ends Coverage

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.

10.5.3 Death

If the subscriber dies, coverage for any enrolled dependents ends on the last day of that month. You may extend your coverage if you meet the requirements for continuation of coverage (see Section 11). The Group must tell us that your coverage is continued, and include your premiums with their regular monthly payment.

10.5.4 Termination, Layoff or Reduction in Hours of Employment

When the subscriber's employment ends, coverage ends on the last day of that month unless you choose to continue coverage (see Section 11).

If you

a. are laid off; or
b. experience a reduction in hours that causes a loss of coverage

And within 6 months you

a. return to active work; or
b. have an increase in hours to qualify for benefits

You and any eligible dependents may enroll in the Plan on the date of rehire or the date you work enough hours to qualify, and coverage will begin on that date. The Group must notify us that you have been rehired following a layoff or that your hours have been increased. 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.

10.5.5 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 the marriage is legally ended (divorce, dissolution, annulment, legal separation, etc.).

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

   i. the child reaches 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

You must tell us 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.

10.5.6 Rescission

Recission means cancelling (rescinding) coverage back to the effective date, as if it had not existed. We may rescind your coverage, or deny claims at any time, for fraud or intentional material misrepresentation by you or the Group. This includes leaving out or not telling us information.

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

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

We will refund any unearned premiums. We may charge a 7 1/2% cancelation fee. You and/or the Group will have to repay benefits that have been paid. We will tell you of a rescission 45 days before your coverage is canceled.

10.6 ELIGIBILITY AUDIT

We have the right to make sure you are eligible. We may ask for documentation including but not limited to member birth certificates, adoption paperwork, marriage documentation, and any other evidence necessary to document eligibility for the Plan.

SECTION 11. CONTINUATION OF HEALTH COVERAGE

Check with the Group to find out if you qualify for continuation coverage. You should read the following sections carefully.

11.1 COBRA CONTINUATION COVERAGE

COBRA continuation coverage does not apply to all groups. Check with the Group to find out if this Plan qualifies. In this COBRA section 11.1, COBRA Administrator means either the Group or the third party administrator they have assigned to handle COBRA administration. Your coverage under COBRA continuation will be the same as that for other members under the Plan.

You may elect COBRA if you are the subscriber and you lose coverage because your employment ended (other than for gross misconduct), or your hours are reduced. Be sure to look at *Special Circumstances at the end of the COBRA section.

If you are the spouse or child of the subscriber, continuation coverage is available if you lose coverage because of:

a. The subscriber's death
b. The subscriber's employment ends (other than for gross misconduct) or their hours of employment with the Group are reduced
c. The subscriber becomes entitled to Medicare
d. Divorce or legal separation from the subscriber*
e. You no longer meet the definition of "child" under the Plan

You must provide written notice to the COBRA Administrator if one of these events occurs. Include: 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. You must give notice no later than 60 days after you lose coverage under the Plan. If notice of the event is not given on time, COBRA is not available.

Electing COBRA. You must elect COBRA within 60 days after plan coverage ends, or, if later, 60 days after the COBRA Administrator sends you notice of your right to elect COBRA.

Each family member* has an independent right to elect COBRA coverage. This means that a spouse or child may elect COBRA even if the subscriber does not.

You are responsible for all COBRA premiums. Due to the 60-day election period, you will owe retroactive premiums for the months between when regular coverage ended and the first payment date. You must pay these premiums in a lump sum at the first payment. The first payment is due within 45 days after you elect coverage (this is the date the election notice is postmarked, if mailed, or the date the COBRA administrator receives it, if hand-delivered). The premium rate may include a 2% add-on to cover administrative expenses. All other payments are due on the 1st of the month. You will not receive a bill for any payments due. If your premiums are not received on time, your COBRA coverage will end and may not be reinstated. You will have a 30-day grace period to pay the premiums.

Length of COBRA
COBRA due to end of employment or a reduction of hours of employment generally lasts up to 18 months.

COBRA because of the subscriber's death, divorce or legal separation, or a child ceasing to be a dependent under the terms of the Plan can last up to a total of 36 months.

If the subscriber became entitled to Medicare benefits less than 18 months before their employment ends or their hours are reduced, COBRA for members (other than the subscriber) who lose coverage because of the employment end/reduction in hours can last up to 36 months after the date of Medicare entitlement.

You and your family may be eligible for a longer period of COBRA coverage if you are disabled or a second qualifying event occurs. You must notify the COBRA Administrator within 60 days of a second qualifying event or becoming disabled. If you do not, you will lose the right to extended COBRA coverage.

If the Social Security Administration determines you are disabled, your 18-month COBRA period may be extended to a total of up to 29 months. The disability must have started before the 61st day of your COBRA coverage period. The Social Security Administration must make its decision before the end of your initial 18-month COBRA period.

You must give a copy of the Social Security Administration's determination of disability to the COBRA Administrator no more than 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 you lose (or would lose) coverage under the terms of the Plan as a result of the subscriber's termination or reduction of hours of employment

Each family member on COBRA can have the disability extension if one of you qualifies. Your COBRA premiums may increase after the 18th month of coverage to 150% of the premiums. Your disability extension ends if you are no longer considered disabled.

If you are a spouse or child on COBRA and a second qualifying event occurs, your maximum COBRA period may be extended to 36 months from the date of the first qualifying event. Second qualifying events may include the death of the subscriber, divorce or legal separation from the subscriber, or a child's no longer being eligible as a dependent under the Plan. These events are a second qualifying event only if they would have caused you to lose coverage if the first qualifying event had not occurred.

When COBRA Ends
COBRA coverage ends after the maximum COBRA period. It will end earlier if your premiums are not paid on time or the Group stops offering any group health plan to its employees. COBRA will also end if:

a. You become covered under another group health plan
b. You become entitled to Medicare benefits after electing COBRA (unless the qualifying event is the Group's bankruptcy)
c. Any reason the Plan would end coverage if you were not receiving COBRA (such as fraud)

Ask the COBRA Administrator if you have any questions about COBRA. Don't forget to tell the COBRA Administrator if your address changes.

***Special Circumstances**
Divorce or legal separation may be a qualifying event even if the subscriber ended your coverage earlier. If you notify the COBRA Administrator within 60 days of the divorce or legal separation, COBRA may be available for the period after the divorce or legal separation.

If the Plan provides retiree coverage and the subscriber's former employer files for bankruptcy, this may be a qualifying event if you lose coverage as a result. Contact the COBRA Administrator for more information about this situation.

11.2 Uniformed Services Employment & Reemployment Rights Act (USERRA)

If the subscriber is called to active duty by any of the armed forces of the United States of America, they may continue coverage under USERRA for up to 24 months or the period of uniformed service leave, whichever is shortest. You must continue to pay your share of the premiums during the leave. If you do not elect continued coverage under USERRA, or you cancel or use up your USERRA continuation, coverage restarts on the day you return to active employment with the Group. All plan provisions and limitations apply as if your Plan coverage had been continuous. You must be released under honorable conditions, and return to active employment within the required timeframe. You can get complete information about your rights under USERRA from the Group.

11.3 Family & Medical Leave

You will remain eligible for coverage during a leave of absence under state or federal family and medical leave laws. If you choose not to stay enrolled, you will be eligible to re-enroll in the Plan on the date the subscriber returns to work. Submit a complete and signed application within 60 days of the return to work. Your coverage will restart as if there had been no break in coverage.

SECTION 12. DEFINITIONS

Aetna® PPO is the travel network you can use to get care while traveling outside the network primary service area. The travel network is not available if you are temporarily living outside the primary service area. To find an Aetna® PPO provider, you can search providers at https://www.aetna.com/asa.

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

Authorization see Prior Authorization.

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

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

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

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

Contracted Provider is a provider contracted with an insurance company to provide healthcare services to members.

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

Cost Sharing is the share of costs you must pay when you get a covered service. It includes deductible, copayments or coinsurance. Cost sharing does not include premiums, balance billing amounts for Tier 3 or out-of-state 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 your prior healthcare coverage including coverage remaining in force at the time you obtain new coverage, as defined in 26 US Code §9801(c)(1).

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

Deductible is the amount of covered expenses you must pay before we start paying. If you get Tier 1, Tier 2 and Tier 3 services, 3 separate deductibles may apply.

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

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

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

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

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

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 your attending physician determines you are 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 you receive the notice and give informed consent.

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

Enrollment Date is, 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, supplies and medications that meet one of the following:

a. Involve a treatment for which scientific or medical assessment has not been completed, or the effectiveness of the treatment has not been generally established. This includes a treatment program that may be proven for some uses, but scientific literature does not support the use as requested or prescribed. An example is a medication that is proven as a treatment when used alone, but scientific literature does not support using it in combination with other therapies.
b. Are available in the United States only as part of 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

First Choice providers are Tier 2 providers to supplement the Pioneer network in Alaska. First Choice providers are not participating in the Pioneer network but provide healthcare to members at discounted rates. To find a First Choice provider, you can search providers at https://www.fchn.com/providersearch/moda-ak.

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

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

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

Implant is a material inserted or grafted into tissue.

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

In-Network Pharmacy is a pharmacy that is contracted under Moda Health to provide pharmacy services to you.

Maximum Plan Allowance (MPA) is the maximum amount we will reimburse providers. For a Tier 1, Tier 2, travel network or out-of-state preferred provider, the MPA is the amount the provider has agreed to accept for a particular service.

MPA for Tier 3 facilities and providers in Alaska is the lesser of billed charges or the 80th percentile of fees commonly charged for a given procedure in a given area, up to 300% of the Alaska Medicare equivalent allowable amount. If an Alaska Medicare equivalent is not available for a drug, durable medical equipment, prosthetic, orthotic, parenteral nutrition, or other supply, the MPA cap is the acquisition cost.

MPA for Tier 3 facilities and providers outside of Alaska is the lesser of billed charges or 125% of the Medicare equivalent allowable amount. If a Medicare equivalent allowable is not available for a drug, durable medical equipment, prosthetic, orthotic, parenteral nutrition or other supply, MPA cap is the acquisition cost. For remaining services without a Medicare equivalent allowable, MPA will be the 50th percentile of fees commonly charged for a given procedure in a given area.

In certain instances, when a dollar value is not available for Medicare equivalent pricing, the claim is reviewed by our medical consultant, who determines a comparable code to the one billed after consultation with and acceptance by the provider. The claim is processed using the comparable code and as described above.

MPA for Tier 3 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 emergency services received out-of-network, out-of-network air ambulance, or out-of-network services in an in-network facility when you are not able to choose the provider is the median Tier 1 and Tier 2 rates derived from an eligible third party data base in accordance with federal regulations in the No Surprises Act.

MPA for Tier 3 and out of state end-stage renal disease (ESRD) facilities is 125% of the Medicare equivalent 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) we access 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 a Tier 3 or out-of-state provider, any amount above the MPA may be your responsibility (this is the balance billing amount) unless balance billing is prohibited by federal law.

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

Medically Necessary means healthcare services, medications, supplies or interventions that a treating licensed healthcare provider recommends and 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 your condition and appropriate considering the potential benefit and harm to you
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.

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

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

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

Mental Health Provider is 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. Where this book refers to "we", "us" or "our" it is referring to Moda Health or its employees.

Network is a group of providers who contract to provide healthcare to you at negotiated rates. These groups are called Preferred Provider Organizations (PPOs) and provide Tier 1 services in their specific service areas. See Section 5 for more information about networks. Covered medical expenses will be paid at a higher rate when a Tier 1 provider is used as shown in Section 3.

Non-Contracted Provider is a provider not contracted under one of our approved networks to provide healthcare services to you.

Out-of-Network Pharmacy is a pharmacy that is not contracted under Moda Health to provide pharmacy services to you.

Out-of-Pocket Maximum is the maximum amount you pay out-of-pocket every year. It includes the deductible, coinsurance and copays. If you get Tier 1, Tier 2 and Tier 3 services, 3 separate out-of-pocket maximums apply. If you reach the out-of-pocket maximum in a calendar year, we will pay 100% of eligible expenses for the rest of the year.

Pioneer refers to the primary network covered at Tier 1 benefit level.

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 getting approval from us before the date of service. A complete list of services and medications that require prior authorization is available on your Member Dashboard or you can ask Customer Service. A service, supply or medication that is not prior authorized when required will result in denial of benefits or a penalty (see section 6.1).

Professional Provider is an autism service provider or any state-licensed or state-certified health care professional, when providing medically necessary services within the scope of their license or certification.

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

Service Area is the geographical area where Tier 1 or Tier 2 providers provide their services.

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

Tier 1 refers to providers that are contracted with Pioneer network or Delta Dental Premier to provide care to you.

Tier 2 refers to providers that are contracted with First Choice in Alaska or Delta Dental Premier to provide care to you.

Tier 3 refers to providers that are not contracted under Moda Health or Delta Dental to provide benefits with discounted rates to you.

TruHearing refers to the hearing services network of audiologists and hearing instrument providers covered at Tier 1 benefit level.

VSP refers to the vision care network of providers covered at Tier 1 benefit level.

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

SECTION 13. GENERAL PROVISIONS & LEGAL NOTICES

13.1 MEMBER DISCLOSURES

You have the right to:

a. Information about the Plan and how to use it, the providers who will care for you, and your rights and responsibilities.
b. Be treated with respect and dignity.
c. Urgent and emergency services, 24 hours a day, 7 days a week.
d. Participate in decision making regarding your healthcare. This includes
    i. 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
    iii. the right to refuse treatment and to be informed of the possible medical result
    iv. filing a statement of wishes for treatment (i.e., an Advanced Directive), or giving someone else the right to make healthcare choices for you when you are unable to (Power of Attorney)
e. Privacy. Personal and medical information will only be used or shared as required or allowed by state and federal law.
f. Appeal a decision or file a complaint about the Plan, and to receive a timely response.
g. Free language assistance services when communicating with us.
h. Make suggestions regarding our member rights and responsibilities policy.

You have the responsibility to:

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

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

Your rights under the Women's Health and Cancer Rights Act of 1998 (WHCRA)
You have benefits for mastectomy related services. This includes all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses and complications resulting from a mastectomy, including lymphedema. Contact Customer Service for more information.

If I am not satisfied with the plan, how can I file an appeal or complaint?
You can file an appeal or complaint by writing a letter to Moda Health. Include the following information:

a. Member name and date of birth
b. Subscriber ID number
c. Contact information (phone, email, mailing address)
d. Provider(s) involved
e. Date(s) of service
f. Medical records from the provider, if applicable
g. Reason for the appeal/complaint
h. Description of what happened
i. Desired outcome

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

13.2 General & Miscellaneous

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.

Confidentiality of Member Information
Keeping your protected health information (PHI) confidential is very important to us. PHI includes enrollment, claims, and medical and dental information. We use this information to pay your claims and authorize services. It is also used for referrals, case management and quality management programs. We do not sell your information. The Notice of Privacy Practices has more detail about how we use your PHI. Follow the Privacy Center link on the Moda Health website for a copy of the notice, or call 855-425-4192.

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

Transfer of Benefits
Only members are entitled to benefits under the Plan. These benefits are not assignable or transferable to anyone else except the provider upon a member's written request.

Correction of Payments or Recovery of Benefits
If Moda Health mistakenly makes a payment for a member to which they are not entitled, or pays a person who is not eligible for payments at all, we have 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. Our right to recovery includes the right to deduct the amount paid from future benefits we would provide for a member even if the mistaken payment was not made on that member's behalf. We will give you or the provider 30

calendar days written notice before recovering a payment. You and the provider have the right to challenge the recovery.

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

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

No Waiver
Any waiver of any provision of the Plan, or any performance under the Plan, must be in writing and signed by the waiving party. Any such waiver shall not operate as, or be deemed to be, a waiver of any prior or future performance or enforcement of that provision or any other provision. If we delay or fail to exercise any right, power or remedy provided in the Plan, including a delay or omission in denying a claim, that shall not waive Moda Health's rights to enforce the provisions of the Plan.

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

Responsibility for Quality of Medical Care
You always have the right to choose your provider. We are not responsible for the quality of your medical care. Your providers act as independent contractors. We cannot be held liable for any injuries you get while receiving medical services or supplies.

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.

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.

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 9.1). All internal levels of appeal under the Plan must be exhausted before filing a legal action in court.

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

13.3 ERISA DUTIES

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

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

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

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

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

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

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

If plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or may file suit in federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, (e.g., if it finds the claim is frivolous).

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

Employee Benefits Security Administration
Seattle District Office, 300 Fifth Avenue, Suite 1110, Seattle, Washington, 98104
Phone 206-757-6781
Information and assistance is also available through their website: dol.gov/agencies/ebsa.

Office of Outreach, Education and Assistance, U.S. Department of Labor
200 Constitution Avenue N.W., Washington D.C. 20210
Phone 866-444-3272
You may call them to obtain publications about your rights and responsibilities under ERISA.

Nondiscrimination notice

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

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

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

If you need any of the above, call:

888-217-2363 (TDD/TTY 711)

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

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

Scott White coordinates our nondiscrimination work:

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

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

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

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

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

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

modahealth.com

2688-NDS-MH+DD-Commercial (01/24)

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۔ 1-877-605-3229 (TTY: 711) پر کال کریں

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

P.O. Box 40384
Portland, OR 97240