2026

Alaska Individual Medical Plan

Moda Select Alaska Bronze 6500 Plan
($6,500 Deductible Plan)
Effective Date *January 1, 2026*

The subscriber may return this policy to Moda Health within 10 days of its delivery and get a refund of the premium paid. If you do this, the policy shall be canceled from the beginning. It will be as if no policy had been issued.

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

This policy is authorized by the signature of Moda Health's representative.

Scott Loftin
Senior Vice President

Moda Health renews this individual policy on January 1st each year. Renewal may include benefit and rate changes. Rates may also change when your family composition changes. In this case, new rates are effective on the first day of the following month.

Individual policies and other services are available at www.modahealth.com.

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SECTION 1. WELCOME TO MODA HEALTH

We are pleased to provide your individual health coverage through the Individual Moda Select Alaska Bronze 6500 Plan. This policy will give you important information about your policy'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 at www.modahealth.com. You can use it 24 hours a day, 7 days a week to get your policy 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 policy is a description of your individual health coverage. This policy may be changed or replaced without the agreement of any member other than the subscriber. You can find the most current policy on your Member Dashboard. All Plan provisions are governed by this policy between the subscriber and Moda Health.

IMPORTANT NOTE: CHILD ONLY COVERAGE
If this is a child only policy, all references in this policy to dependents, including a spouse, domestic partner or children, are considered deleted. Siblings of the subscriber are eligible.

SECTION 2. MEMBER RESOURCES

2.1 CONTACT INFORMATION

Moda Health Website (log in to **y**our **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 and supply you need must be prior authorized www.modahealth.com/medical/referral

Medical Customer Service Department
Toll-free 844-274-9117
En Español 888-786-7461

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

Dental Customer Service Department
Toll-free 844-235-8014

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
cirrusmd.com/modahealth

Pharmacy Customer Service Department
Toll-free 844-235-8016

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

Telecommunications Relay Service for the hearing impaired
711

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

Health Insurance Marketplace
www.healthcare.gov or 1-800-318-2596
En Español - www.cuidadodesalud.gov or 1-800-318-2596

2.2 Member ID Card

After you enroll, we will send you ID (identification) cards that show your ID number 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. These are the networks for your plan:

Medical networks
Tier 1 Moda Select
Tier 2 First Choice in Alaska

Dental network
Delta Dental Premier

Pharmacy network
Navitus

Out-of-Area network
Aetna® PPO Network through Aetna Signature Administrators®
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. 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

You can find other general information about the policy in Section 12.

SECTION 3. SCHEDULE OF BENEFITS

Look through this section for a quick summary of the policy'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 11.

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	**$6,500** Tier 2 deductible applies	**$7,500** Tier 1 deductible applies	**$22,500**
Maximum annual deductible per family	**$13,000** Tier 2 deductible applies	**$15,000** Tier 1 deductible applies	**$45,000**
Annual out-of-pocket maximum per member	**$9,000** Tier 2 out-of-pocket maximum applies	**$9,000** Tier 1 out-of-pocket maximum applies	**$27,000**
Maximum annual out-of-pocket per family	**$18,000** Tier 2 out-of-pocket maximum applies	**$18,000** Tier 1 out-of-pocket maximum applies	**$54,000**

Services	Amount You Pay			Section in Handbook & Details
	Tier 1	**Tier 2**	**Tier 3**	
Urgent & Emergency Care				
Ambulance Transportation	30% after deductible Tier 1 deductible and out-of-pocket maximum apply			Section 7.2.1
Commercial Transportation	30% after deductible	30% after deductible	30% 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)	30% after deductible Tier 1 deductible and out-of-pocket maximum apply			Section 7.2 and 7.2.4
ER professional/ ancillary services billed separately	30% after deductible Tier 1 deductible and out-of-pocket maximum apply			
Urgent Care Office Visits	$75 per visit	40% after deductible	60% after deductible	Section 7.2.5
Medical Transportation	30% after deductible	30% after deductible	30% 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%	0%	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
Mammogram	0%	0%	0%	Section 7.3.8 One age 35 - 40 One per year, age 40+

Services	Amount You Pay			Section in Handbook & Details
	Tier 1	**Tier 2**	**Tier 3**	
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	30% after deductible	50% after deductible	60% after deductible	
Prostate Rectal Exam	$45 per visit	40% after deductible	60% after deductible	Section 7.3.6 One per year, age 40+
Prostate Specific Antigen (PSA) Test	30% after deductible	50% after deductible	60% after deductible	
General Treatment Services				
Acupuncture	$45 per visit	50% after deductible	60% after deductible	Section 7.4.1 24 visits per year
Anticancer Medication	30% after deductible	50% after deductible	60% after deductible	Section 7.4.2
Applied Behavior Analysis	30% after deductible	50% after deductible	60% after deductible	Section 7.4.3
Behavioral Health Services				Section 7.4.4 $5, no deductible, for first 2 Tier 1 office visits
Detoxification (Detox)	30% after deductible	50% after deductible	60% after deductible	
Office Visits	$45 per visit	40% after deductible	60% after deductible	
Intensive Outpatient	$45 per visit	40% after deductible	60% after deductible	
Other Outpatient Services	30% after deductible	50% after deductible	60% after deductible	
Inpatient	30% after deductible	50% after deductible	60% after deductible	
Partial Hospitalization	30% after deductible	50% after deductible	60% after deductible	
Residential Treatment Program	30% after deductible	50% after deductible	60% after deductible	
Biofeedback	30% after deductible	50% 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%	60% after deductible	
Minor restorative services	10% after deductible	10% after deductible	60% after deductible	
Other dental services	30% after deductible	30% after deductible	60% after deductible	
Orthodontia	30% after deductible	30% after deductible	60% after deductible	When medically necessary
Dental Injury	30% after deductible	50% after deductible	60% after deductible	Section 7.4.9
Diabetes Services	30% after deductible	50% after deductible	60% after deductible	Section 7.4.10 Supplies covered under Pharmacy benefits
Diagnostic and Supplemental Breast Exam, Biopsy and Consultation	0%	0%	0%	Section 7.3.8
Diagnostic Procedures, including x-ray & lab				Section 7.4.11
Outpatient	30% after deductible	50% after deductible	60% after deductible	
Inpatient	30% after deductible	50% after deductible	60% after deductible	
Durable Medical Equipment, Supplies & Appliances	30% after deductible	50% after deductible	60% after deductible	Section 7.4.12 Limits apply to some DME, supplies, appliances
Home Healthcare	30% after deductible	50% after deductible	60% after deductible	Section 7.4.16 130 visits per year
Hospice Care				Section 7.4.17
Home Care	30% after deductible	50% after deductible	60% after deductible	
Inpatient Care	30% after deductible	50% after deductible	60% after deductible	10 days
Respite Care	30% after deductible	50% after deductible	60% after deductible	240 hours
Hospital Inpatient Care	30% after deductible	50% after deductible	60% after deductible	Section 7.4.18
Hospital Physician Visits	30% after deductible	50% after deductible	60% after deductible	Section 7.4.19
Infusion Therapy (Home or Outpatient)	30% after deductible	50% after deductible	60% after deductible	Section 7.4.20

Services	Amount You Pay			Section in Handbook & Details
	Tier 1	**Tier 2**	**Tier 3**	
Kidney Dialysis	30% after deductible	50% after deductible	60% after deductible	Section 7.4.21
Massage Therapy	$45 per visit	50% after deductible	60% after deductible	Section7.4.22 24 visits per year
Nutritional Therapy				Section 7.4.25
Preventive, as required under the Affordable Care Act	0%	0%	60% after deductible	
Treatment (medical and behavioral health)	30% after deductible	50% after deductible	60% after deductible	
Office and Home Visits				Section 7.4.26
PCP Visits				See also Virtual Care Visits First 2 visits including virtual care visits Naturopathic physicians are considered specialists unless credentialed as a PCP
First 2 PCP visits	$5 per visit	40% after deductible	60% after deductible	
Additional PCP visits	$45 per visit			
Specialist Visits	$75 per visit	40% after deductible	60% after deductible	Section 7.4.26
Psychological or Neuropsychological Testing	30% after deductible	50% after deductible	60% after deductible	Section 7.4.30 12 hours per year
Outpatient Rehabilitation & Habilitation	$75 per visit	40% after deductible	60% after deductible	Section 7.4.32 45 sessions per year Limits apply separately to rehabilitation and habilitation services
Inpatient Rehabilitation	30% after deductible	50% after deductible	60% after deductible	Section 7.4.31 30 days per year
Skilled Nursing Facility Care	30% after deductible	50% after deductible	60% after deductible	Section 7.4.33 60 days per year
Spinal Manipulation	$45 per visit	50% after deductible	60% after deductible	Section 7.4.34 24 visits per year
Surgery & Invasive Diagnostic Procedures				Section 7.4.35
Outpatient	30% after deductible	50% after deductible	60% after deductible	
Inpatient	30% after deductible	50% after deductible	60% after deductible	

Services	Amount You Pay			Section in Handbook & Details
	Tier 1	Tier 2	Tier 3	
Temporomandibular Joint Syndrome (TMJ)	30% after deductible	50% after deductible	60% after deductible	Section 7.4.36
Therapeutic Injections	30% after deductible	50% after deductible	60% after deductible	Section 7.4.37
Therapeutic Radiology	30% after deductible	50% after deductible	60% after deductible	Section 7.4.38
Transplants				Section 7.4.39 Includes donor costs
Center of Excellence facilities	30% after deductible	N/A	N/A	
Other facilities	Not covered	Not covered	Not covered	
Travel, Lodging & Meals	30% after deductible	30% after deductible	30% after deductible	$7,500 per transplant
Virtual Care Visits				Section 7.4.40
First 2 visits	$5 per visit	40% after deductible	60% after deductible	First 2 visits combined with in-person PCP visits
Additional visits	$35 per visit	40% after deductible	60% after deductible	
Through CirrusMD	0%	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%	
Maternity	30% after deductible	50% after deductible	60% after deductible	Section 7.5
Pharmacy				
Prescription Medication	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	$2		$2	
Select Tier	30% after deductible		30% after deductible	
Preferred Tier	30% after deductible		30% after deductible	
Nonpreferred Tier	45% after deductible		45% after deductible	

Services	Amount You Pay			Section in Handbook & Details
	Tier 1	**Tier 2**	**Tier 3**	
Mail Order Pharmacy			Must use Moda-designated mail order pharmacy	
Value Tier	$6			
Select Tier	30% after deductible			
Preferred Tier	30% after deductible			
Nonpreferred Tier	45% after deductible			
Specialty Pharmacy				Up to 30-day supply for most medications
Preferred Specialty	35% after deductible	35% after deductible	N/A	Must use Moda-designated specialty pharmacy.
Nonpreferred Specialty	45% after deductible	45% after deductible	N/A	
Anticancer Medication	30% after deductible	30% after deductible	30% after deductible	Section 7.4.2 Pharmacy tier deductible applies Mail order and specialty must use Moda-designated pharmacies
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
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

Services	Amount You Pay			Section in Handbook & Details
	Tier 1	Tier 2	Tier 3	
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
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 Tier 2 up to $1,000 maximum every 2 years for all services, testing and aids.
Hearing Coverage				
Hearing exam	20%		20%	Section 7.8 Hearing exams once per year. Ear examination once per 2 years. Other services, including one hearing aid per ear, once in a 3-year period.
Hearing testing & hardware	20%		20%	
Additional Accident Benefit				
Additional Accident Benefit	0%	0%	0%	Section 4.4 $1,000 maximum. Services must be completed within 90 days of the injury

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 we begin sharing costs with you.

Once a family member has met their per member deductible, we 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 show 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.

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.

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 services benefits

4.3 PAYMENT

Moda Health pays covered expenses based on 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 11}. 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 ADDITIONAL ACCIDENT BENEFIT

If you have an accidental injury while you are covered by the policy, you will not have to pay covered expenses to treat the injury for the first 90 days, up to a maximum per accident. You will have to pay the standard cost sharing for services after you reach the dollar maximum or after 90 days, whichever comes first. Accidental injury does not include damage caused by routine or normal body movements such as stooping, twisting, bending or chewing. It does not include any condition related to pregnancy or services provided as a result of over-exertion or muscle strains.

4.5 EXTRA-CONTRACTUAL SERVICES

Moda Health works with you and your professional providers to consider effective alternatives to hospitalization and other care to make more efficient use of the Plan's benefits. If we believe a service or supply is medically necessary, cost effective and beneficial for quality of care, we may cover the service or supply even though the policy does not allow it. This is called an extra-contractual (outside the policy 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 we have paid benefits for extra-contractual services for a member does not obligate us to pay such benefits for any other member, nor does it obligate us 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 policy.

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 Moda Select network by using Find Care on your Member Dashboard or a Tier 2 provider in First Choice 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

Medical networks are:
Tier 1: Moda Select (see service area below)*
Tier 2: First Choice (Alaska outside the Moda Select service area)

Tier 1 and Tier 2
When you do not have reasonable access (within 50 miles) from your residence to a Tier 1 provider, you can use a Tier 2 provider at the Tier 1 benefit level.

Services will be paid at the Tier 2 benefit level if:

a. A Tier 1 provider is available within 50 miles of your home
b. You choose to travel outside the 50-mile range and there is a Tier 1 provider available in the area you have traveled to

Out-of-Area networks are Affinity and Aetna® PPO Network.

You will be assigned to the out-of-area networks if you are an enrolled child living in the United States but outside the Moda Select service area. If your enrolled child moves outside the service area, you must contact Customer Service and the subscriber's employer to update the address with Moda Health.

When you are traveling in the United States but outside the Moda Select network service area, you may use the out-of-area networks.

Pharmacy network is Navitus
Vision network is VSP
Dental network is Delta Dental Premier

Moda Select service area in Alaska is:
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. If you move outside of the service area, you will lose eligibility on the Plan.

5.1.2 Primary Care Provider (PCP)

The Plan is designed to support your healthcare needs through partnership between you and a Tier 1 primary care provider (PCP) who can coordinate your care. We encourage you to choose a Tier 1 PCP group and tell us who it is when you enroll. A PCP group is the primary care group (such as a clinic) where PCPs work, and is where you access primary (non-specialty) care.

You can change your PCP group at any time through your Member Dashboard or by calling Customer Service. Use Find Care on your Member Dashboard to see a list of Tier 1 PCPs, or ask Customer Service for help. Each member of your family may choose a different PCP group.

A PCP may be a family or general practitioner, an internal medicine practitioner, a pediatrician, a nurse practitioner, an OB/GYN practitioner, a geriatric practitioner, or a naturopathic practitioner credentialed as a PCP.

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, the benefit from the Plan is lower, at the Tier 3 benefit level. In most cases you must pay the provider all charges at the time of treatment, and then file a claim to be reimbursed the out-of-network benefit. If the provider's charges are more than the maximum plan allowance, you may be 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.

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 Moda Select 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

To find a PCP group:

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 PCP groups.

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.

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 manipulations 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

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

6.1.2 Prior Authorization Limitations

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

a. An authorization is valid for a set period of time. Authorized services 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 11.

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

Many services must be prior authorized (see section 6.1). 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 this policy
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 is terminated, we 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 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 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.

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 11) 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 11) 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.

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 condition 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 7.4.26). 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 levels). 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 guaiac-based fecal occult blood test (gFOBT) or fecal immunochemical test (FIT) every year
b. Fecal DNA test, including MT-sDNA or sDNA-FIT or FIT-DNA every 3 years
c. CT colonography, flexible sigmoidoscopy or double contrast barium enema every 5 years
d. Flexible sigmoidoscopy every 10 years plus FIT every year
e. Colonoscopy, including polyp removal, every 10 years

With the exception of colonoscopy, screening tests involve 2 steps. If you have a positive result on a USPSTF-recommended screening covered under the preventive benefit, one follow-up colonoscopy to confirm the 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 exams and laboratory tests are covered as recommended by your professional provider. You are at high risk if you have 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 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. 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, horse-assisted therapy, creative arts therapy, wilderness or adventure camps, music therapy, neurofeedback, chelation or hyperbaric chamber
c. Services provided under an individual education plan (IEP) to comply with the Individuals with Disabilities Education Act
d. Services provided by the Department of 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 your 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) twice per calendar year
   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. See section 7.4.36 for TMJ benefits.

b. Preventive
   i. Prophylaxis twice per calendar year (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 twice per calendar year
   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. See section 7.4.36 for TMJ benefits.

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 and connector bar.

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 7.4.8(h)(vi)).

Your dentist may provide virtual dental visits, or you can use Teledentistry.com.
You may want a virtual visit when you:

a. Have an after-hours dental issue
b. Have a dental emergency and you do not have a regular dentist
c. Want a dental consultation without leaving home
d. Are traveling and need dental assistance

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 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, if 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 covered by this policy
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 (no cost sharing Tier 1 and Tier 2)
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 behavioral health condition.

Diagnostic services including:

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 (missing lens) 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 policy

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 7.4.35):
    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 sections 7.4.12 and 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 you 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 provide 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:

i. Hospice services provided to other than the terminally ill member, including bereavement counseling for family members
ii. 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 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.

7.4.24 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.

7.4.25 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.

7.4.26 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 2 PCP home and office 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 for the first 2 PCP visits 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

7.4.27 Phenylketonuria
We cover the formulas necessary for the treatment of phenylketonuria.

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

7.4.29 Pre-admission Testing
Preadmission testing is covered when ordered by a professional provider.

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

7.4.31 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.

7.4.32 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.

7.4.33 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 covered by this policy
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

7.4.34 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. Spinal manipulations must be prior authorized.

7.4.35 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.

7.4.36 Temporomandibular Joint Syndrome (TMJ)

TMJ related surgical procedures and splints require prior authorization. They are covered only when medically necessary because of problems including pain and/or not being able to chew properly, or in cases involving severe acute trauma. Orthodontia services and treatment of related dental diseases or injuries are 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 7.4.23 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 7.4.35).

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 policy, 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 this policy
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 plan 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 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 sharing 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 policy
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 your 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 ask Customer Service.

7.6.3 Specialty Services & Pharmacy

Specialty medications are often used to treat complex chronic health conditions. Your pharmacist and other professional providers will tell you if your prescription must be prior authorized or if you must get it from a Moda-designated specialty pharmacy. Find out about the clinical services and if your medication is a specialty 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, your 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 set. 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 policy 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.
i. **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.
h. **Non-Covered Condition.** A medication prescribed for reasons other than to treat a covered medical condition.
i. **Nutritional Supplements and Medical Foods.**
j. **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.
k. **Over the Counter (OTC) Medications** and certain prescription medications that have an OTC option (see the preferred drug list on your Member Dashboard), except those treating tobacco dependence.
l. **Pharmacies Excluded from the Network.** Medications from pharmacies that have been excluded from the network for non-compliance with fraud, waste and abuse laws.
m. **Repackaged Medications.**
n. **Replacement Medications and/or Supplies.**
o. **Vitamins and Minerals.** Except as required by law.
p. **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 their 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 medications that we have reviewed and found to be safe and effective at a better price compared to other medications in the same therapeutic class and/or category. Generic medications that have not been shown to be safer or more effective than other more cost effective generic medications are included in this tier.

Prescription Medication List. Our Moda Health Prescription Medication List is on your Member Dashboard. It gives you information about how commonly prescribed medications are covered.

Not every covered medication is on the list. We will review new medications and may set coverage limitations.

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 Care 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 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.

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 (anti-reflective coating, polycarbonate, progressive, and scratch-resistant coating). 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. One audiological (hearing) exam and evaluation by a certified or licensed audiologist or hearing aid specialist is covered annually. One hearing aid per ear is covered once 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. A hearing aid (monaural or binaural) prescribed as a result of the examination
b. Ear molds
c. Hearing aid instruments
d. Initial batteries, cords and other necessary supplementary equipment
e. A warranty
f. Follow-up consultation within 30 days following delivery of the hearing aid
g. 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 aid 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 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 policy 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 7.4.35)

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 11)

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 your 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 veterans coverage

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

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 9.4.3)

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

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 individuals who do not have an 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 by 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 no workers' compensation coverage is provided to you.

SECTION 9. CLAIMS ADMINISTRATION & PAYMENT

9.1 SUBMISSION & PAYMENT OF CLAIMS

9.1.1 Notice of Claim

A claim is not payable until the service or supply has actually been received. Written notice of claim must be given to us as soon as reasonably possible after the occurrence or commencement of a loss covered by the policy. 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. Notice may be given by you or on your behalf to Moda Health at P.O. Box 40384, Portland, Oregon 97240.

You are not required to use a specific claim form. Information on how you can submit notice of a claim when your provider does not submit a claim form on your behalf is found in sections 9.1.2 to 9.1.7.

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.

9.1.2 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 ID number
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.

9.1.3 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.

9.1.4 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.

9.1.5 Payment of Claims

We will pay benefits for services by a Tier 3 provider directly to the provider if there is an assignment of benefits. You may revoke an assignment of benefits by giving written notice to us and to the provider. The written notice to us must certify that written notice of revocation has been given to the provider. Revocation of an assignment of benefits is not effective until the notice of revocation is received by us and the provider.

Your right to assign benefits to a Tier 3 or out-of-state provider may be transferred to another person who is not a member by a qualified domestic relations order, which is an order or judgment in a divorce or dissolution action under AS 25.24 that designates a person to determine to whom indemnities for a named beneficiary should be paid under a healthcare insurance policy. Rights under the qualified domestic relations order do not take effect until the order is received by us.

9.1.6 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.

9.1.7 Claim Inquiries

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

9.1.8 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 additional 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 complete its processing 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 9.1.1.

9.1.9 Time Frames for Processing Prior Authorizations and Utilization Review

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. If your appeal is about initial eligibility, you will need to contact the Health Insurance Marketplace.

9.2.1 Time Limit for Submitting Appeals

If your appeals are not on time, you may lose the right to any appeal. You have **180 days** from the date you receive notice of an adverse benefit determination to send us your written appeal.

The timelines addressed in section 9.2 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 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 12.1). 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 Appeals

If your appeal is about eligibility, including premium tax credit and allocations or American Indian and Alaskan Native eligibility status, send your appeal to the Health Insurance Marketplace.

We will investigate appeals of other adverse benefit determinations. 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. You may review the claim file and submit written comments, documents, records and other information to support your appeal. You may choose a person (representative) to act on your behalf. You must sign an authorization to disclose

protected health information (PHI) allowing your representative to act for you. You may find this form on modahealth.com. Contact Customer Service for help assigning your representative. 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 after we have received those appeals, unless you fail to provide enough information for us to make a decision. In this case, 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. The investigation of an urgent care claim will be completed no later than 48 hours following the earlier of (a) when we receive the specified information, or (b) the end of the period provided to submit the specified additional information.

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.

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. We will send a written notice of the decision to you, including the reason for the decision, and if applicable, information on the right to external review.

9.2.3 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.

9.2.4 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 section 9.2.3. 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 they receive 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.

9.2.5 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.

9.2.6 Additional Member Rights

You have the right to file a complaint or ask for help 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 99501-3567
Email: insurance@alaska.gov
Internet: www.commerce.alaska.gov/web/ins/Consumers/Complaint.aspx

9.2.7 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 or the Health Insurance Marketplace 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 or the Health Insurance Marketplace 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 policy.

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 this policy 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 policy 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 provider
   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 policy and the other plan(s) will be coordinated. This means one plan pays its full benefits first, 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 policy 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 policy 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, and surrogacy, are complicated and specific. We have included some high-level information here. Contact Customer Service for more information.

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

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

If this is a child only policy: Coverage is only available to age 26. Dependent children, spouses, and domestic partners of the subscriber are not covered. Any wording that talks about coverage for spouses, domestic partners or children does not apply to your policy. Siblings of the subscriber are eligible. Coverage of new siblings may be effective on either the date of birth, adoption or placement for adoption or on the first of the following month.

You cannot be covered by more than one Moda Health individual medical policy at a time.

Eligibility and enrollment, are administered by the Health Insurance Marketplace. Contact the Health Insurance Marketplace for information. You may add newly acquired or newly eligible dependents to the policy. The subscriber must submit an application and any required supporting documentation within 60 days of their eligibility. A new dependent may cause your premium to go up. Their coverage will not start until we get the required premium or any applicable premium credit.

You must notify the Health Insurance Marketplace if you add or drop family members from coverage, even if it does not change your premiums. You must tell us and the Health Insurance Marketplace whenever your address changes.

To be eligible and stay eligible for coverage, you must meet the Health Insurance Marketplace's residency requirements. This includes living in the service area, and intending to live in the service area permanently or indefinitely. Coverage is not available if your main reason for living in the service area is to get health coverage or other temporary purpose such as getting treatment.

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 or the subscriber's parent 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 not a 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.

10.1 ELIGIBILITY AUDIT

We have the right to make sure you are eligible. We may ask for documentation including but not limited to medical and certain financial records and birth certificates, adoption paperwork, marriage certificates, domestic partner registration, proof of residency and any other evidence necessary to document your eligibility on the policy.

10.2 PREMIUMS

The amount of premium you owe is shown on your premium notice. You may contact the Health Insurance Marketplace about premium tax credits.

We must receive your premium payments every month to keep your coverage active. You can pay by check, cashier's check, money order or prepaid debit card with a billing statement, or by electronic fund transfer (EFT). Electronic billing (eBill) is also available. This lets you pay your monthly premium on your Member Dashboard using your bank account.

To change how you make payments, the subscriber must give us notice in advance. To stop paying by EFT, you must tell us at least 15 days before the next deduction date. To change other billing options, we need at least 30 days advance notice. We cannot stop your eBill payment. You will have to make any eBill changes by updating your payment preferences in eBill yourself.

We do not accept premium payments by third parties, except when required by law.

10.2.1 When Payments are Due

All premium payments are due on the first of the month. You should plan to pay on or before the due date. You will have some extra time (a grace period) after the premium due date to get your payment to us.

If we do not receive your payment before the end of the grace period (section 10.2.2), this policy will end after an advance delinquency and termination notice (see section 10.3).

This policy continues for each month you pay your premium on time.

10.2.2 Grace Period

Unless within 30 days before the premium due date we have delivered to the subscriber or mailed to the last address, as shown by our records, written notice of our intention not to renew this policy beyond the period for which the premium has been accepted, you will have a 10 day grace period for payment after the premium due date, during which grace period the policy shall continue in force. If you are eligible for tax credits and taking any portion as a prepaid subsidy, you will be allowed a 3 month grace period after the first premium has been paid in full within 10 days of the due date.

10.2.3 Reinstatement

If any renewal premiums are not paid within the time allowed for payment, a subsequent acceptance of premiums by us or by any agent authorized by us to accept such premiums shall be subject to an application for reinstatement and a conditional receipt will be issued for the premiums received. The policy will be reinstated upon approval of such application by us or, lacking such approval, upon the 45th day following the date of the conditional receipt unless we have previously notified the subscriber in writing of its disapproval of the application. The reinstatement policy only covers claims resulting from an accidental injury sustained after the date of reinstatement and claims due to sickness beginning more than 10 days after the reinstatement date. In all other respects, we (the subscriber and Moda Health) shall have the same rights as we had under the policy immediately before the due date of the defaulted premium, subject to any provisions added in connection with the reinstatement. Any premiums accepted in connection with a reinstatement shall be applied to a period for which premiums have not been previously paid, but not to any period more than 60 days prior to the date of

reinstatement. Premium payments must be through electronic fund transfer (EFT) upon reinstatement.

10.2.4 Changes in Amount of Premiums

Premiums can change without notice when your family composition or eligibility status changes. The new premium will be effective on the first day of the month after the event. When you move into the next age bracket of the rate table, premiums will change on the renewal date. If there is a change in premiums that affects all policyholders, we will tell you about this in writing 45 days before it takes effect. When the new premium is paid, this confirms that the subscriber accepts the change.

10.2.5 Segregation of Premium for Abortion Services

The first full dollar of your monthly premium is set aside for abortion services for which public funding is prohibited. Federal regulations require us to collect this premium for these services even if you cannot use or do not intend to use the services.

10.3 When Coverage Ends

These circumstances will cause your coverage to end:

a. The subscriber is no longer eligible for coverage through the Health Insurance Marketplace
b. You move outside the Plan's service area
c. The dependent is no longer eligible as a dependent
d. Premium is not paid
e. Rescission for fraud or intentional material misrepresentation (see section 10.4)
f. We end this health benefit plan option
g. We are decertified to offer plans through the Health Insurance Marketplace
h. Subscriber ends their coverage after the required advanced notice or changes health benefit plans during an open enrollment or special enrollment period

Coverage ends on the last day of the month through which premiums are paid unless otherwise required by law. If your coverage was paid with financial assistance in the form of tax credits through the Health Insurance Marketplace, coverage ends on the last day of the first month of the grace period.

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

10.4 Rescission

Rescission 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.

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 information that is the basis for eligibility
c. Submitting false or altered claims

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

SECTION 11. DEFINITIONS

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 that have developed because of tooth loss.

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

Domestic Partner is a person joined with the subscriber in a partnership that has either been registered under the laws of any federal, state or local government or that meets the following criteria:

The domestic partner and subscriber

a. Are at least 18 years of age
b. Share a close personal relationship and are responsible for each other's welfare
c. Are each other's sole domestic partner
d. Are not legally married or registered and have not had a spouse or domestic partner within the prior 6 months. If previously married or in a partnership, the 6-month period starts on the final date of divorce or dissolution of partnership
e. Are not related by blood closer than would bar marriage in the state of Alaska
f. Were mentally competent to contract when their domestic partnership began
g. Have jointly shared the same regular and permanent residence for at least 6 months
h. Are jointly financially responsible for basic living expenses defined as the cost of food, shelter and any other expenses of maintaining a household. Financial information must be provided if requested

Effective Date is the date coverage actually begins. For new policyholders, this is the first day of the month after we receive your application unless another date is selected. For new dependents, it is the date of birth for a newborn child, the date of the adoption decree for an adopted child, and the date of placement for a child placed for adoption or foster care. For new spouses and domestic partners, or if you qualify due to loss of minimum essential coverage, it is the first day of the month after the qualifying event.

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.

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

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 Moda Select network in Alaska. First Choice providers are not participating in the Moda Select 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.

Health Insurance Marketplace refers to the federally facilitated entity established to administer the state health insurance exchange program.

Healthcare Insurance Plan is a healthcare insurance policy or contract provided by a healthcare insurer but does not include an excepted benefits policy or contract.

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, out-of-area 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 225% 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 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 person whose application for individual healthcare insurance coverage has been accepted and who is enrolled for coverage under the terms of this policy. A member may be the subscriber or a dependent of a subscriber. Where this book refers to "you" or "your" it is referring to a member.

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

a. Board certified psychiatrist
b. Psychologist or psychological associate
c. Mental health nurse practitioner or psychiatric mental health clinical nurse specialist
d. Clinical social worker or master social worker
e. Professional counselor, mental health counselor, or marriage and family therapist

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.

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

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.

The **Plan** is the individual healthcare insurance plan insured under the terms of this policy between the subscriber and Moda Health.

The **Policy** is the contract between the subscriber and Moda Health that contains all the conditions of the insurance coverage. The policy includes the application, this document, and any declaration pages, addendums, appendices, amendments, endorsements and riders.

The **Policy Year** is the period commencing on the effective date of the policy to the following December 31st and every 12 months from January 1st through December 31st thereafter. Moda Health renews the Plan every policy year, including benefits and rate adjustments.

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).

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

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

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

Subscriber is the person in whose name the policy is issued after the Health Insurance Marketplace accepts that person's individual application.

Tier 1 refers to providers that are contracted with Moda Select 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 aid providers covered at Tier 1 benefit level.

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

SECTION 12. GENERAL PROVISIONS & LEGAL NOTICES

12.1 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. changing to a new primary care physician (PCP) group
    ii. a discussion of appropriate or medically necessary treatment options, no matter how much they cost or if they are covered
    iii. the right to refuse treatment and 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 properly 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.

12.2 General & Miscellaneous

Entire Policy
This policy plus the application and any declaration pages, addendums, endorsements or amendments are the entire contract between the parties. No promises, terms, conditions or obligations exist other than those contained in the contract. No change in this policy shall be valid until approved by an executive officer of Moda Health and unless the approval is endorsed or attached to the policy. No agent has authority to change this policy or to waive any of its provisions. This policy plus any application, declaration page, 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.

Modification of Policy
We will provide notification of a change in covered services, benefits or premiums to the subscriber at least 45 days before the change is effective.

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 this policy. 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 applicant 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 member, a copy of which has been given to the subscriber or member or member's beneficiary.

No Waiver
Any waiver of any provision of this policy, or any performance under this policy, 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 this policy, including a delay or omission in denying a claim, that shall not waive Moda Health's rights to enforce the provisions of the policy.

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 this policy 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 this policy 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, this policy 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 9.1.1). All internal levels of appeal under the Plan must be exhausted before filing a legal action in court.

Time Limit for Certain Defenses
After 3 years from the date of issue of this policy no misstatements, except fraudulent misstatements, made by the applicant in the application for the policy shall be used to void the policy or to deny a claim for loss incurred commencing after the expiration of the 3-year period.

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.

Guaranteed Renewability
We are required to renew your coverage if the subscriber wants to renew. Medicare eligibility is not a basis for non-renewal of this policy.

Coverage may only be discontinued or non-renewed based on one or more of the following:

a. **Nonpayment of premiums.** You have not paid premiums or contributions in accordance with the terms of this policy or we have not received timely premium payments
b. **Fraud.** You have performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of this policy
c. **Medicare.** When we have knowledge that a member is entitled to Medicare Part A or enrolled in Medicare Part B and it duplicates benefits under this policy.
d. **Termination of plan.** We are ceasing to offer coverage in the individual market in accordance with the provisions in the next paragraph and applicable state law
e. **Movement outside service area.** In the case of healthcare insurance coverage offered through a network plan, you no longer reside, live, or work in the service area (or in an area for which we are authorized to do business) but only if such coverage is terminated under this paragraph uniformly without regard to any health status-related factor of the members
f. **Association membership ceases.** In the case of healthcare insurance coverage that is made available in the individual market only through one or more bona fide associations, the membership of the subscriber in the association (on the basis of which the coverage is provided) ceases but only if such coverage is terminated under this paragraph uniformly without regard to any health status-related factor of the members

When Moda Health non-renews or discontinues healthcare insurance coverage in the individual market, there are requirements for uniform termination of coverage.

a. **A healthcare insurance plan not offered.** In any case in which we decide to discontinue offering one healthcare insurance plan offered in the individual market, that plan may be discontinued only if:
    i. We provide notice to each subscriber covered under that plan of such discontinuation at least 90 days prior to the date of the discontinuation of that plan
    ii. We offer each subscriber covered under that plan the option to purchase any other individual healthcare insurance plan currently being offered for members in such market
    iii. in exercising the option to discontinue coverage of a plan and in offering the option of coverage under other plans as described in the preceding bullet, we act uniformly without regard to any health status-related factor of a current or prospective member

b. **Discontinuance of all healthcare insurance plans.**

i. In general. In any case in which we elect to discontinue offering all healthcare insurance plans in the individual market in a state, these plans may be discontinued only if:

A. We provide notice to the applicable state authority and to each subscriber of such discontinuation at least 180 days prior to the date of the expiration of such plans

B. all healthcare insurance issued or delivered for issuance in the state in such market is discontinued and coverage under such health insurance plans in such market is not renewed

ii. Prohibition on market reentry. In the case of a discontinuation in the individual market as described in the preceding bullet, we may not provide for the issuance of any healthcare insurance plan in the market and the state involved during the 5-year period beginning on the date of the discontinuation of the last healthcare insurance plan not so renewed

Notwithstanding the regulations on discontinuance and nonrenewal, we are permitted to make uniform modification of healthcare insurance plans. At the time of plan renewal, we may modify any healthcare insurance plan offered to subscribers in the individual market so long as such modification is consistent with state law and effective on a uniform basis among all subscribers with that plan.

In applying this section in the case of healthcare insurance plans that are made available by us in the individual market to persons only through one or more associations, a reference to a person is deemed to include a reference to such an association (of which the person is a participating member).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ເຊີນຊາບ: ຖ້າທ່ານເວົ້າພາສາ ລາວ,
ຈະມີບໍລິການຊ່ວຍດ້ານພາສາແບບບໍ່ເສຍຄ່າໃຫ້ທ່ານ.
ມີເຄື່ອງຊ່ວຍ ແລະ
ການບໍລິການແບບບໍ່ເສຍຄ່າທີ່ເໝາະສົມເພື່ອໃຫ້ຂໍ້ມູນໃນຮູບ
ແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້. ໂທຫາເບີ 1-877-605-3229
(TTY: 711) ຫຼື ລົມກັບຜູ້ໃຫ້ບໍລິການຂອງທ່ານ.

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

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

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

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

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

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

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

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

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

AKIYESI: Ti o ba sọ Yorùbá, awọn iṣẹ iranlọwọ ede ọfẹ wa fun ọ. Awọn iranlọwọ iranlọwọ ti o yẹ ati awọn iṣẹ lati pese alaye ni awọn ọna kika wiwọle tun wa laisi idiyele. Pe 1-877-605-3229 (TTY: 711) tabi sọrọ si olupese rẹ.

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

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

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