2026

Idaho Individual Medical Policy

Moda Select Idaho Silver 4000 Plan
($4,000 Deductible Plan)

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

Scott Loftin
Senior Vice President

The subscriber may return this policy to Moda Health within 10 days of its delivery date 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 provided by Moda Health Plan, Inc.

ModaIDIndvMCbk-off 1-1-2026

TABLE OF CONTENTS

SECTION 1. WELCOME TO MODA HEALTH 1

SECTION 2. MEMBER RESOURCES 2

2.1 CONTACT INFORMATION 2
2.2 MEMBER ID CARD 3
2.3 NETWORKS 3
2.4 CARE COORDINATION 3
2.4.1 Care Coordination 3
2.4.2 Disease Management & Health Coaching 3
2.4.3 Behavioral Health 4
2.5 OTHER RESOURCES 4

SECTION 3. SCHEDULE OF BENEFITS 5

SECTION 4. PAYMENT & COST SHARING 11

4.1 DEDUCTIBLES 11
4.2 MAXIMUM OUT-OF-POCKET 11
4.3 PAYMENT 11
4.4 EXTRA-CONTRACTUAL SERVICES 12

SECTION 5. NETWORK INFORMATION 13

5.1 GENERAL NETWORK INFORMATION 13
5.1.1 Network and Service Area 13
5.1.2 Coverage Outside the Service Area for Certain Children 13
5.1.3 Primary Care Provider (PCP) 14
5.1.4 Out-of-Network Care 14
5.1.5 Care After Normal Office Hours 14
5.2 USING FIND CARE 15
5.2.1 Primary Care Providers 15
5.2.2 DME Providers 15

SECTION 6. PRIOR AUTHORIZATION 16

6.1 PRIOR AUTHORIZATION REQUIREMENTS 16
6.1.1 Services Requiring Prior Authorization 16
6.1.2 Prior Authorization Limitations 16
6.1.3 Second Opinion 17

SECTION 7. BENEFIT DESCRIPTION 18

7.1 WHEN BENEFITS ARE AVAILABLE 18
7.2 URGENT & EMERGENCY CARE 18
7.2.1 Ambulance Transportation 18
7.2.2 Emergency Room Care 19
7.2.3 Urgent Care 19
7.3 PREVENTIVE SERVICES 20
7.3.1 Colorectal Cancer Screening 20

7.3.2 Contraception 21
7.3.3 Immunizations 21
7.3.4 Pediatric Screenings 21
7.3.5 Preventive Health Exams 21
7.3.6 Prostate Cancer Screening 22
7.3.7 Tobacco Cessation 22
7.3.8 Women's Healthcare 22
7.4 General Treatment Services 22
7.4.1 Anticancer Medication 22
7.4.2 Applied Behavior Analysis (ABA) 23
7.4.3 Behavioral Health 23
7.4.4 Biofeedback 24
7.4.5 Clinical Trials 24
7.4.6 Dental Injury 25
7.4.7 Diabetes Services 25
7.4.8 Diagnostic Procedures 25
7.4.9 Durable Medical Equipment (DME), Supplies & Appliances 26
7.4.10 Enterostomal Therapy 27
7.4.11 Gender Affirming Services 27
7.4.12 Hearing Services 27
7.4.13 Home Healthcare 28
7.4.14 Hospice Care 28
7.4.15 Hospital Care 29
7.4.16 Hospital Visits 29
7.4.17 Inborn Errors of Metabolism 29
7.4.18 Infusion Therapy 30
7.4.19 Kidney Dialysis 30
7.4.20 Maxillofacial Prosthetic Services 30
7.4.21 Medication Administered by Provider, Treatment/Infusion Center or Home Infusion Therapy 30
7.4.22 Nonprescription Enteral Formula for Home Use 31
7.4.23 Nutritional Therapy 31
7.4.24 Office or Home Visits 31
7.4.25 Podiatry Services 31
7.4.26 Pre-admission Testing 31
7.4.27 Rehabilitation & Habilitation 31
7.4.28 Skilled Nursing Facility Care 32
7.4.29 Spinal Manipulation 32
7.4.30 Surgery 32
7.4.31 Therapeutic Injections 33
7.4.32 Therapeutic Radiology and Chemotherapy 33
7.4.33 Transplants 34
7.4.34 Virtual Care Visits (Telemedicine) 34
7.4.35 Pediatric Vision Services 35
7.4.36 Adult Vision Exam 35
7.5 Maternity Care 36

7.5.1 Breastfeeding Support 36
7.5.2 Circumcision 36
7.5.3 Diagnostic Procedures 36
7.5.4 Involuntary Complications of Pregnancy 36
7.5.5 Office, Home or Hospital Visits 36
7.5.6 Hospital Benefits 37
7.6 Pharmacy Prescription Benefit 37
7.6.1 Definitions 37
7.6.2 Covered Medication Supply 38
7.6.3 90-Day Supply at Participating Retail Pharmacies 39
7.6.4 Mail Order Pharmacy 40
7.6.5 Specialty Services & Pharmacy 40
7.6.6 Self-Administered Medication 40
7.6.7 Step Therapy 40
7.6.8 Limitations 40
7.6.9 Exclusions 41

SECTION 8. GENERAL EXCLUSIONS 42

SECTION 9. CLAIMS ADMINISTRATION & PAYMENT 49

9.1 Submission & Payment of Claims 49
9.1.1 Notice of Claim and Claim Forms 49
9.1.2 How to Send Us Claims 49
9.1.3 Prescription Medication Claims 50
9.1.4 Timely Payment of Claims 50
9.1.5 Explanation of Benefits (EOB) 50
9.1.6 Claim Inquiries 51
9.2 Complaints, Appeals & External Review 51
9.2.1 Time Limit for Submitting Appeals 51
9.2.2 Definitions 51
9.2.3 The Review Process 52
9.2.4 External Review 53
9.2.5 Complaints 55
9.2.6 Additional Member Rights 55
9.3 Continuity of Care 56
9.4 Benefits Available from Other Sources 57
9.4.1 Coordination of Benefits (COB) 57
9.4.2 Coordination with Medicare 60
9.4.3 Third Party Liability 60
9.4.4 Surrogacy 61

SECTION 10. ELIGIBILITY & ENROLLMENT 62

10.1 Child Only Policy 62
10.2 Subscriber 62
10.3 Dependents 62
10.4 New Dependents 63
10.5 Open Enrollment Period 63

10.6 Special Enrollment 63
10.7 Premiums 64
10.7.1 Making Payments 64
10.7.2 When Payments are Due 65
10.7.3 Changes in Amount of Premiums 65
10.7.4 Unearned Premium 65
10.8 Guaranteed Renewability 65
10.9 When Coverage Ends 66
10.9.1 Premium is Not Paid 66
10.9.2 Subscriber Ends Coverage 66
10.9.3 Death 66
10.9.4 Loss of Eligibility by Dependent 66
10.9.5 Moving Out of the Service Area 66
10.9.6 Reinstatement 66
10.9.7 Rescission 67
10.9.8 We Refuse to Renew 67
10.10 Time Limit on Certain Defenses 67
10.11 Extension of Benefits 67
10.11.1 Extension of Benefits for Continuous Loss 67
10.11.2 Pregnancy Benefit Extension 68
10.12 Eligibility Audit 68

SECTION 11. DEFINITIONS 69

SECTION 12. GENERAL PROVISIONS & LEGAL NOTICES 75

12.1 Member Disclosures 75
12.2 General & Miscellaneous 76

SECTION 13. NOTICE OF YOUR RIGHTS UNDER NO SURPRISES ACT 80

SECTION 1. WELCOME TO MODA HEALTH

We are pleased to provide your individual health coverage through this managed care 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/idaho. You can use it 24 hours a day, 7 days a week to get your policy information whenever it is convenient.

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.

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.

IMPORTANT NOTES:

ESSENTIAL HEALTH BENEFITS

Except for pediatric dental, this policy covers the essential health benefits as defined by the Secretary of the U.S. Department of Health and Human Services. Annual and lifetime maximum dollar limits are not applied to any service that is an essential health benefit.

The policy you are applying for does not include coverage for pediatric dental care, which is considered an essential health benefit under the Affordable Care Act. Pediatric dental care is available in the market and can be purchased as a stand-alone product. Please contact your insurance agent, your health insurance company, or Your Health Idaho if you wish to purchase a stand-alone dental care product.

FOR 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.

THIS IS NOT A MEDICARE SUPPLEMENT POLICY

This policy is not a Medicare Supplement policy. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare. You can get this from CMS on medicare.gov.

SECTION 2. MEMBER RESOURCES

2.1 CONTACT INFORMATION

Moda Health Website (log in to the **Member Dashboard**)
www.modahealth.com/idaho

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

- Find an in-network provider with Find Care
- Get medication cost estimates and benefit tiers using our Prescription Price check tool and formulary
- See if a service or supply you need must be prior authorized first
- Review this policy and other services

Medical Customer Service Department
1-844-931-1775
En español 888-786-7461

Behavioral Health Customer Service Department
888-217-2373

Disease Management and Health Coaching
877-277-7281

Virtual Care preferred vendor
CirrusMD
modahealth.com/cirrusmd

Pharmacy Customer Service Department
844-931-1780

Vision Care Services Customer Service Department
800-877-7195

Hearing Services preferred vendor
TruHearing
866-202-2178

Appeals Department
601 SW 2nd Ave., Portland, OR 97204
Fax 503-412-4003
IdahoAppealReview@modahealth.com

Telecommunications Relay Service for the hearing impaired
711

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

2.2 MEMBER ID CARD

After you enroll, we will send you ID (identification) cards that show your 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

This policy pays benefits only for services provided in the networks shown below. Network Information (Section 5) explains how networks work. These are the networks for your Plan:

Medical Network
Moda Select – Idaho counties Ada, Adams, Bannock, Bear Lake, Benewah, Bingham, Boise, Bonner, Bonneville, Boundary, Canyon, Caribou, Cassia, Clearwater, Elmore, Franklin, Fremont, Gem, Jefferson, Idaho, Kootenai, Latah, Lewis, Minidoka, Madison, Nez Perce, Oneida, Owyhee, Payette, Power, Shoshone, Teton and Washington

Pharmacy Network
Navitus

Vision network
VSP

Out-of-Area Networks
Moda Select, Affinity Limited, Aetna® PPO

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 locate in-network providers and understand your mental health and substance use disorder benefits.

2.5 OTHER RESOURCES

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

SECTION 3. SCHEDULE OF BENEFITS

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

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

You will find details of the actual benefits in the sections after this summary. You will need to know the conditions, limitations and exclusions that are explained there. Prior authorization may be required for some services (see Section 6). Important terms are explained in **Error! Reference s ource not found.**.

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

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

	In-Network Benefits	**Out-of-Network Benefits**
Annual medical deductible per member	**$4,000**	**$8,000**
Maximum annual medical deductible per family	**$8,000**	**$16,000**
Annual out-of-pocket maximum per member	**$7,500**	**$75,000**
Maximum annual out-of-pocket maximum per family	**$15,000**	**$150,000**

Services	**Cost Sharing** (Deductible applies unless noted differently)		**Section in Handbook & Details**
	In-network	**Out-of-network**	
Urgent & Emergency Care			
Ambulance Transportation	40% In-network deductibles and out-of-pocket maximums apply		Section 7.2.1
Emergency Room Facility (includes ancillary services)	$350 In-network deductibles and out-of-pocket maximums apply		Section 7.2.2
Urgent Care Office Visit	$50 per visit	60% after deductible	Section 7.2.3
Preventive Services			
Services as required under the Affordable Care Act, including the following:	0%	60% after deductible	Section **Error! Reference s ource not found.**
Colonoscopy	0%	60% after deductible	Section **Error! Reference s ource not found.** One per 10 years, age 45+

Services	Cost Sharing (Deductible applies unless noted differently)		Section in Handbook & Details
	In-network	Out-of-network	
Contraception	0%	60% after deductible	Section 7.3.2
Immunizations	0%	60% after deductible	Section 7.3.3
Mammogram	0%	60% after deductible	Section 7.3.8 One per year, age 40+
Pediatric Screenings	0%	60% after deductible	Section 7.3.4 Age/frequency limits apply
Preventive Health Exams	0%	60% after deductible	Section 7.3.5 6 visits in first year of life 7 exams from age 1 - 4 One per year, age 5+
Tobacco Cessation Treatment			Section 7.3.7
Consultation & Supplies	0%	60% after deductible	
Women's Exam & Pap Test	0%	60% after deductible	Section 7.3.8 One per year. Supplemental breast cancer screening as described in Section 7.3.8.1
Other Preventive Services including:			
Screening X-ray & Lab	40% after deductible	60% after deductible	Section 7.4.8
Prostate Rectal Exam	$5 per visit	60% after deductible	Section **Error! Reference s ource not found.** Once every year
Prostate Specific Antigen (PSA) Test	40% after deductible	60% after deductible	
General Treatment Services			
Anticancer Medication	40% after deductible	60% after deductible	Section 7.4.1
Applied Behavior Analysis	40% after deductible	60% after deductible	Section **Error! Reference s ource not found.**
Behavioral Health Services			Section **Error! Reference s ource not found.**
Detoxification (Detox)	40% after deductible	60% after deductible	
Office Visits	$5 per visit	60% after deductible	
Intensive Outpatient	$5 per visit	60% after deductible	
Other Outpatient Services	40% after deductible	60% after deductible	
Inpatient	40% after deductible	60% after deductible	

Services	Cost Sharing (Deductible applies unless noted differently)		Section in Handbook & Details
	In-network	Out-of-network	
Partial Hospitalization	40% after deductible	60% after deductible	
Residential Treatment Program	40% after deductible	60% after deductible	
Biofeedback	$50 per visit	60% after deductible	Section **Error! Reference s ource not found.** 10 visit lifetime maximum
Dental Injury	40% after deductible	60% after deductible	Section 7.4.6
Diabetes Services	40% after deductible	60% after deductible	Section 7.4.7 Supplies covered under Pharmacy benefits
Diagnostic Procedures, including x-ray and lab			Section 7.4.8
Outpatient	$60 per day per provider	60% after deductible	
Inpatient	40% after deductible	60% after deductible	
Advanced Imaging	40% after deductible	60% after deductible	
Durable Medical Equipment (DME) Supplies & Appliances	40% after deductible	60% after deductible	Section 7.4.9
Hearing Aids & Related Services			Section 7.4.12 For dependent children under specific medical conditions Frequency limits apply
Exam	$45 per visit	60% after deductible	
Other services	40% after deductible	60% after deductible	
Home Healthcare	40% after deductible	60% after deductible	Section 7.4.13
Hospice Care			Section 7.4.14
Home Care	40% after deductible	60% after deductible	
Inpatient Care	40% after deductible	60% after deductible	
Respite Care	40% after deductible	60% after deductible	
Hospital Inpatient Care	40% after deductible	60% after deductible	Section 7.4.15 We pay up to $2,000 per day for out-of-network non-emergency admission
Hospital Physician Visits	40% after deductible	60% after deductible	Section 7.4.16

Services	Cost Sharing (Deductible applies unless noted differently)		Section in Handbook & Details
	In-network	Out-of-network	
Infusion Therapy (Home or Outpatient)	40% after deductible	60% after deductible	Section **Error! Reference s ource not found.** Some medications may be limited to certain providers or settings. Certain medications covered under specialty pharmacy benefit.
Kidney Dialysis	40% after deductible	60% after deductible	Section 7.4.19
Nutritional Therapy			Section **Error! Reference s ource not found.**
Preventive, as required under the Affordable Care Act	0%	60% after deductible	
Treatment (medical and behavioral health)	40% after deductible	60% after deductible	Nutritional therapy for eating disorders must be authorized after first 5 visits
Office and Home Visits			Section 7.4.24 See also Virtual Care Visits under Other Services
PCP Visits	$5 per visit	60% after deductible	
Specialist Visits	$50 per visit	60% after deductible	
Rehabilitation & Habilitation(Physical, occupational and speech therapy)			Section 7.4.27 Up to 20 outpatient sessions per year. Limits apply separately to rehabilitation and habilitation services Limits do not apply to mental health/substance use disorder
Outpatient	$50 per visit	60% after deductible	
Inpatient	40% after deductible	60% after deductible	We pay up to $2,000 per day for out-of-network non-emergency admission.
Skilled Nursing Facility Care	40% after deductible	60% after deductible	Section 7.4.28 30 days per year
Spinal Manipulation	$50 per visit	60% after deductible	Section 7.4.29 18 visits per year
Surgery & Invasive Diagnostic Procedures			Section **Error! Reference s ource not found.**
Outpatient	40% after deductible	60% after deductible	
Inpatient	40% after deductible	60% after deductible	
Therapeutic Injections	40% after deductible	60% after deductible	Section 7.4.31

Services	Cost Sharing (Deductible applies unless noted differently)		Section in Handbook & Details
	In-network	Out-of-network	
Therapeutic Radiology	40% after deductible	60% after deductible	Section **Error! Reference s ource not found.**
Transplants			
Center of Excellence facilities	40% after deductible	N/A	Section 7.4.33 Up to 14 days per transplant for travel and housing
Other facilities	60% after deductible	60% after deductible	
Virtual Care Visits			Section 7.4.34 Log on via modahealth.com/cirrusmd
Through CirrusMD	$0	N/A	
Other providers	$0 per visit	60% after deductible	
Maternity Services			
Breastfeeding			Section 7.5.1
Support and Counseling	0%	60% after deductible	
Supplies		0%	
Maternity	40% 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 Pharmacy deductible applies
Retail Pharmacy			Up to 90-day supply per prescription One copay for a 30-day supply
Value Tier	$2	$2	
Select Tier	$20	$20	
Preferred Tier	40%	40%	
Nonpreferred Tier	50% after deductible	50% after deductible	
Mail Order Pharmacy			Up to 90-day supply per prescription Must use Moda-designated mail order pharmacy or other pharmacies that agree to follow our terms for mail order pharmacies.
Value Tier	$6	$6	
Select Tier	$60	$60	
Preferred Tier	40%	40%	
Nonpreferred Tier	50% after deductible	50% after deductible	
Specialty Pharmacy			Prior authorization required for non-Moda-designated specialty pharmacies. Up to 30-day supply per prescription for most medications
Preferred Specialty	40%	40%	
Nonpreferred Specialty	50% after deductible	50% after deductible	

Services	Cost Sharing (Deductible applies unless noted differently)		Section in Handbook & Details
	In-network	Out-of-network	
Anticancer Medication	40% after deductible	40% after deductible	Section 7.4.1 Prior authorization required for non-Moda-designated pharmacies.
Vision			
Pediatric Vision Care			Section 7.4.35 Under age 19 No deductible
Exam	0%	60%	One per year
Lenses & frames or contacts	0%	60%	One pair per year Frames from the Otis & Piper Eyewear collection only
Optional Lenses and Treatments	0%	60%	
Low vision evaluation	0%	60%	One every year
Low vision services	0%	60%	4 visits every 5 years for follow up care
Low vision aids	0%	60%	One low vision aid per year and one pair of high power spectacles per year
Adult Vision Exam	$10 per visit	60%	Section 7.4.36 Age 19+ One per year

SECTION 4. PAYMENT & COST SHARING

4.1 DEDUCTIBLES

Every year, you will have to pay some expenses before we start paying. This is called meeting or satisfying your deductible. The deductible is lower when you use in-network providers. You must pay all covered expenses until you have spent the deductible amount, unless the policy specifically says there is no deductible. Then we begin sharing costs with you. The deductible amounts, and the amount you pay after the deductible is met, are shown in Section 3. In-network and out-of-network services have separate deductibles. If more than one member of your family is covered, you only have to pay your per member deductible until the total family deductible is reached.

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

4.2 MAXIMUM OUT-OF-POCKET

The policy 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, we 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. In-network and out-of-network out-of-pocket maximums add up separately and are not combined.

Prior authorization penalty, 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 for disallowed charges and out-of-pocket expenses for transplants not performed at a center of excellence, even after the out-of-pocket maximum is met. Disallowed charges may include amounts over the MPA and expenses incurred due to brand substitution.

4.3 PAYMENT

Moda Health pays covered expenses based on the maximum plan allowance (MPA). The MPA is defined in 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 policy benefit limitations, in-network providers agree to look solely to Moda Health, if it is the paying insurer, for compensation of covered services provided to members.

4.4 EXTRA-CONTRACTUAL SERVICES

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 policy'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 shall not obligate us to pay such benefits for any other member, nor shall 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

When you use an in-network provider, you will receive quality healthcare and will have a higher level of benefits. Use Find Care on your Member Dashboard to choose an in-network provider. You may contact Customer Service if you need help. Your member ID card will list your network.

When you are at an in-network facility, your care may be provided by physicians, anesthesiologists, radiologists or other professionals who are not in-network. When you receive services from these out-of-network providers, you may have to pay any amounts charged above the MPA when permitted by law (see section 5.1.4). This is called balance billing. Remember to ask providers to send any lab work or x-rays to an in-network facility.

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

5.1 GENERAL NETWORK INFORMATION

5.1.1 Network and Service Area

Your network provides services in your service area. If you use an in-network provider, your out-of-pocket cost is lower.

Ask your providers (both professional providers and facilities) if they participate with the specific network listed below. Contact Customer Service if you need help finding an in-network provider.

Networks

Medical network is Moda Select, with providers in your service area of Ada, Adams, Bannock, Bear Lake, Benewah, Bingham, Boise, Bonner, Bonneville, Boundary, Canyon, Caribou, Cassia, Clearwater, Elmore, Franklin, Fremont, Gem, Jefferson, Idaho, Kootenai, Latah, Lewis, Minidoka, Madison, Nez Perce, Oneida, Owyhee, Payette, Power, Shoshone, Teton and Washington counties.

If you are outside your service area, then additional networks are available, with providers in the Moda Select, Affinity Limited, Aetna® PPO networks.
Pharmacy network is Navitus
Vision network is VSP

5.1.2 Coverage Outside the Service Area for Certain Children

Enrolled children who live in the United States but outside the medical network service area may be assigned to the out-of-area network. They must be a full-time student or under a Qualified Medical Support Order (QMCSO). Covered services by providers not participating in the out-of-area network are at a lower benefit level.

What you need to do:

a. When a child under a QMCSO is added, you must contact Customer Service to provide the documentation, including their address.

b. When an enrolled child moves outside the medical network service area, you must contact Customer Service to provide documentation of the child's enrollment in an out-of-area school and give us their new address.

The enrolled child will be assigned to the out-of-area network on the first day of the month after we receive the documentation and update the address.

Out-of-Area Networks

- Idaho counties outside the Moda Select network: Aetna® PPO
- All other areas: Aetna® PPO, Moda Select, Affinity Limited

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

When out-of-area children are traveling in the Moda Select service area, they must use the Moda Select network, even though they are assigned to the out-of-area network. Tell us when your child moves back into the service area.

5.1.3 Primary Care Provider (PCP)

The Plan is designed to support your healthcare needs through partnership between you and an in-network primary care provider (PCP) who can coordinate your care. You are encouraged to choose an in-network PCP from family practice and general practice physicians, general internists, pediatricians, obstetricians, gynecologists and other professional providers who received designation from us as a PCP.

You can change your PCP at any time. Use Find Care on your Member Dashboard to see a list of in-network PCPs, or ask Customer Service for help. Each member of your family may choose a different PCP. A PCP may be a family or general practitioner, a pediatrician or a women's healthcare provider.

A women's healthcare provider is an in-network obstetrician or gynecologist, physician assistant or advanced registered nurse practitioner specializing in women's health, or certified nurse midwife, practicing within their lawful scope of practice.

5.1.4 Out-of-Network Care

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

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

5.1.5 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 in-network providers. To search for in-network providers, log in to your Member Dashboard at modahealth.com/idaho and click on Find Care.

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

5.2.1 Primary Care Providers

You are encouraged to choose a PCP. To find a PCP:

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

The search will bring up a list of PCPs.

5.2.2 DME Providers

Find an in-network DME provider for savings on your DME:

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

The search will bring up a list of in-network 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 clinical practice guidelines and guidance from the FDA. We will authorize medically necessary services, supplies or medications based on your medical condition. You may be required to use a preferred treatment center or provider for the treatment to be covered. Treatments are covered only when there is medical evidence of need.

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

6.1 PRIOR AUTHORIZATION REQUIREMENTS

When you use an out-of-network provider, you are responsible for making sure that your provider contacts us for prior authorization. If your services are not authorized in advance, we will apply a penalty of 50% up to a maximum deduction of $2,500 for each occurrence before regular plan benefits begin. The prior authorization penalty does not count toward the Plan's deductible or out-of-pocket maximum.

Prior authorization is not required for an emergency admission. The penalty will not apply in the case of an emergency admission.

6.1.1 Services Requiring Prior Authorization

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

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

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

6.1.2 Prior Authorization Limitations

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

a. An authorization is valid for a set period of time. Authorized services you get outside of that time may not be covered
b. The treatment, services or supplies/medications that will be covered may be limited
c. The number, amount or frequency of a service or supply may be limited
d. You may have to get treatment from a preferred treatment center or other certain provider for the service or supply to be covered at a higher benefit level. 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 ask you to see another provider for an independent review to confirm that non-emergency treatment is medically necessary. When we do this, you will not pay anything for the second opinion.

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

SECTION 7. BENEFIT DESCRIPTION

The services and supplies described in this handbook are covered when they are medically necessary to diagnose and/or treat a medical condition, or are preventive services. We explain the benefits and the conditions, limitations and exclusions in the following sections. An explanation of important terms is in Section 11.

Payment of covered expenses is always limited to the maximum plan allowance. Some benefits have visit 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). If your services are not authorized in advance or you do not use the authorized provider, we may not pay any benefits. You may have to pay the full charge or a prior authorization penalty.

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 a limitation or exclusion applies, benefits will not be paid.

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

7.2 URGENT & EMERGENCY CARE

Emergency services and urgent care are covered. Emergency services are covered at the in-network benefit level. You are covered for treatment of emergency medical conditions (as defined in Section 11) worldwide. If you believe you have a medical emergency, call 911 or seek care from the nearest appropriate provider.

If you get emergency care outside the United States, you will have to pay for those services at that time and send a claim to Moda Health as described in section 9.1.2.

7.2.1 Ambulance Transportation

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

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

7.2.2 Emergency Room Care

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 in-network benefit level. Even when you use an in-network emergency room, some of the providers working in the emergency room and/or hospital may be out-of-network providers (see section 5.1.4 for more information). These out-of-network providers may not bill you, and you do not have financial responsibility, for an amount greater than the applicable cost sharing and deductible under the policy. Likewise, at an out-of-network emergency room, you cannot be balance billed except when permitted by law.

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

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

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

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

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

7.2.3 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 7.4.24). Services will not be paid under your urgent care benefits 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 you get the care from an in-network provider (see Section 3 for benefit level when services are provided out-of-network). Coverage limitations are based on reasonable medical management techniques where permitted by the ACA. This means that you may have member cost sharing for some alternatives in the services listed below:

a. Evidence-based services rated A or B by the United States Preventive Services Taskforce (www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations/)
b. Immunizations recommended by the Advisory Committee on Immunization Practices of the Center for Disease Control and Prevention (ACIP)(www.cdc.gov/vaccines/hcp/acip-recs/)
c. Preventive care and screenings recommended by the Health Resources and Services Administration (HRSA) for infants, children and adolescents (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.

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

7.3.1 Colorectal Cancer Screening

One of the following services, including related charges, if you are age 45 or over:

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

Anesthesia that is medically necessary for colorectal cancer screening is covered under the preventive benefit. If the anesthesia is determined not medically necessary, 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 for colorectal cancer, screening exams and laboratory tests are covered as recommended by the treating professional provider. You are high risk if you have a family medical history of known genetic disorders that predispose you to a high lifetime risk of colorectal cancer (such as Lynch syndrome), having had colorectal cancer or an adenomatous polyp before, or having had inflammatory bowel disease. Screening exams and laboratory tests, including a follow-up colonoscopy to check progress of the original finding, 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 hormonal contraceptives (oral, injectable, patch, ring), devices such as IUDs and implantables (including insertion and removal), and diaphragms and cervical caps are covered. The plan also covers sterilization and counseling. You can find a complete and current list of FDA-approved contraceptive methods here: Birth Control Chart English (fda.gov). When you use an in-network provider and the most cost effective option (e.g., generic instead of brand name), you will not have to pay for contraception except for a vasectomy that is subject to standard cost sharing. If your provider determines the cost-effective contraception is medically inadvisable for you, we will cover an alternative that they prescribe at no cost-sharing. Over the counter contraceptives are covered under the Pharmacy benefit (section 7.6.2). Surgery to reverse a vasectomy or tubal ligation is not covered.

7.3.3 Immunizations

Routine immunizations are limited to those recommended by the ACIP. Immunizations only for travel or to prevent illness that may be caused by 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, including:

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

7.3.5 Preventive Health Exams

Covered according to the following schedule:

a. Newborn: one hospital visit
b. Infants: 6 well-baby visits during the first year of life
c. Age 1 to 4: 7 exams
d. Age 5 and 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 appropriate immunizations, screening laboratory tests and other diagnostic procedures.

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

7.3.6 Prostate Cancer Screening

The Plan covers appropriate screening once every year, including prostate rectal exam and prostate specific antigen (PSA) test or when recommended by your provider. Cost sharing applies to prostate cancer screening.

7.3.7 Tobacco Cessation

Covered expenses include counseling, office visits, medical supplies and medications provided or recommended by a tobacco cessation program or other professional provider.

7.3.8 Women's Healthcare

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

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

Preventive screening, genetic counseling and genetic testing for breast cancer (BRCA) is covered with no cost sharing. Prior authorization is required for genetic testing.

Supplemental Breast Cancer Screening

You are entitled to one supplemental breast screening per year if you are considered to have increased risk of breast cancer. Increased risk factors include a personal or family history of breast cancer, BRCA1 or BRCA2 gene mutations, and Li-Fraumeni syndrome, Cowden syndrome, or Bannayan-Riley-Ruvalcaba syndrome.

This supplemental screening may be conducted using either standard or abbreviated magnetic resonance imaging, contrast mammogram imaging, or, if such imaging is not possible, ultrasound if recommended by the treating physician to screen for breast cancer when there is no abnormality seen or suspected in the breast.

This supplemental screening will have no cost sharing if you choose an in-network provider.

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.

Some services may need a separate prior authorization. If your doctor does not get the required prior authorization, the charges may not be covered based on utilization review. You may have to pay the full cost or a penalty. See section 6.1 for more information about prior authorization.

7.4.1 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 or get prior authorization to use a non-designated specialty pharmacy (see section 7.6.6). For some anticancer medications, you may have to enroll in programs to help make sure the medication is used properly and/or lower the cost of the medication. You can find more information on your Member Dashboard or by contacting Customer Service.

7.4.2 Applied Behavior Analysis (ABA)

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

ABA for autism spectrum disorder is covered. Services must be prior authorized.

Examples of what we do not cover:

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

7.4.3 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, ACT, STAR and TMS must be prior authorized. See section 7.4.8 for coverage of diagnostic services.

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

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

A partial hospital program is an appropriately licensed behavioral health facility providing no less than 4 hours of direct, structured treatment services per day. 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
The following services by a mental health provider are covered:

a. Office or home visits, including psychotherapy
b. Intensive outpatient program
c. Case management, skills training, wrap-around services and crisis intervention
d. Assertive Community Treatment (ACT) and Strength through Active Recovery (STAR) programs
e. Transcranial magnetic stimulation (TMS) and electroconvulsive therapy
f. 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 dependency upon foods, tobacco or tobacco products. Services to assess and treat substance use disorder in an outpatient treatment program 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.

7.4.4 Biofeedback
Biofeedback therapy services are only covered to treat tension or migraine headaches. There is a lifetime limit to how many visits we will cover.

7.4.5 Clinical Trials
If you are enrolled in or participating in an approved clinical trial, usual care costs are covered. Usual care costs mean medically necessary conventional care, items or services that are covered if you get them outside of a clinical trial. The cost sharing will be the same as if they were not part of a clinical trial.

Your policy does not cover items or services:

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

We must prior authorize your participation in a clinical trial.

Approved clinical trials are limited to those that are:

a. Funded or supported by a center or cooperative group that is funded by the National Institutes of Health, the Centers for Disease Control and Prevention, the Agency for

Healthcare Research and Quality, the Centers for Medicare and Medicaid Services, the U.S. Department of Energy, the U.S. Department of Defense or the U.S. Department of Veterans Affairs
b. Conducted as an investigational new drug application, an investigational device exemption or a biologics license application to the U.S. Food and Drug Administration
c. Exempt by federal law from the requirement to submit an investigational new drug application to the U.S. Food and Drug Administration

7.4.6 Dental Injury

Dental services are not covered, except to treat an accidental injury to your natural teeth. Natural teeth are teeth that grew in your mouth. To be covered, all the following must be true:

a. The accidental injury must have been caused by a foreign object or was caused by acute trauma (e.g., 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 is completed within 12 months of the date of injury
d. Treatment is medically necessary and you get it from 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.

7.4.7 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 7.6.2), when you buy them from a pharmacy with a valid prescription and using a preferred manufacturer (see the preferred drug list on your Member Dashboard). Insulin pumps may be covered under the DME benefit (section 7.4.9) if you do not get them from a pharmacy.

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

a. HbA1c lab test
b. Checking for kidney disease
c. Annual dilated eye exam or retinal imaging, including one by an optometrist or ophthalmologist
d. Diabetes self-management programs, including diabetes assessment and training program
e. Dietary or nutritional therapy
f. Routine foot care (see section 7.4.25)

7.4.8 Diagnostic Procedures

Services must be for treatment of a medical or behavioral health condition. Some of these procedures may need to be prior authorized. Diagnostic services include:

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

Your provider must get prior authorization for most advanced imaging services (see section 6.1). 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 on the Moda Health website or you may ask Customer Service.

7.4.9 Durable Medical Equipment (DME), Supplies & Appliances

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

Some examples of DME, supplies and appliances are:

a. CPAP for sleep apnea
b. Glasses or contact lenses, only if you have aphakia (missing lens) or keratoconus
c. Hospital beds and accessories
d. Insulin pumps
e. Intraocular lenses within 90 days of cataract surgery
f. Light boxes or light wands
g. Orthotics, orthopedic braces, orthopedic shoes to restore or maintain your ability to do day to day activities or perform your job. If you can get the correction or support you need by modifying a mass-produced shoe, then we will only cover the cost of the modification.
h. Oxygen and oxygen supplies
i. Prosthetics
j. Wheelchair or scooter (including maintenance expenses) may be limited to one per year under age 19 and one every 3 years age 19 and over based on utilization review

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 7.6.2 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.

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

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

Exclusions

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

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

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.

7.4.10 Enterostomal Therapy

Enterostomal therapy for patients with stomas, complex wounds and incontinence is covered.

7.4.11 Gender Affirming Services

Expenses for gender affirming treatment are covered for members over age 18 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 7.4.30):
    i. Breast/chest surgery
    ii. Gonadectomy (hysterectomy/oophorectomy or orchiectomy)
    iii. Reconstruction of the genitalia
    iv. Gender affirming facial surgery

7.4.12 Hearing Services

We cover hearing services for enrolled dependent children with a birth defect or acquired hearing loss that may result in cognitive or speech development deficits if without intervention. Covered hearing services include:

a. Hearing evaluations
b. One hearing aid per hearing impaired ear every 3 years
c. Bone conduction sound processors, including examinations and fittings
a. Ear molds and replacement ear molds
b. Outpatient speech therapy up to 45 visits every year when billed for hearing loss

The hearing aid must be prescribed, fitted and supplied by an audiologist or hearing aid specialist and referred by a licensed physician.

Cochlear Implants
Cochlear implants are covered for members of all ages when medically necessary and prior authorized.

7.4.13 Home Healthcare

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

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

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

Home health aides are not covered. If you are in hospice, your home healthcare, home care services, and supplies are covered under sections 7.4.14 and 7.4.9.

7.4.14 Hospice Care

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

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

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

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

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

Hospice Inpatient Care
Short term hospice inpatient services and supplies are covered.

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

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

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

7.4.15 Hospital Care

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

a. Hospital room
b. Intensive care unit
c. Isolation care to protect you or other patients from spreading illness
d. Facility charges for surgery performed in a hospital outpatient department
e. Other hospital services and supplies when medically necessary for treatment and ordinarily provided by a hospital
f. Take-home prescription drugs are limited to a 3-day supply at the same benefit level as hospitalization

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

A hospital is a facility, including a hospital owned or operated by the state of Idaho, 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.

7.4.16 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.

7.4.17 Inborn Errors of Metabolism

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

7.4.18 Infusion Therapy

We cover the following medically necessary infusion therapy services and supplies. Your provider must get prior authorization for infusion therapy.

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 your response to therapy

You may have to use a preferred medication supplier, home infusion provider or provider office infusion for some medications. When we limit authorization to a certain supplier, provider or setting, medications you get from other suppliers or infusion therapy administered at a hospital outpatient facility or other provider may not be covered. Some infusion medications from a preferred medication supplier are covered under the pharmacy specialty medication benefit (see Section 3 and section 7.6.5). See section 7.6.6 for self-administered infusion therapy. Some services and supplies are not covered if your provider bills them separately. They are considered included in the cost of other billed charges.

7.4.19 Kidney Dialysis

Covered expenses include:

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

7.4.20 Maxillofacial Prosthetic Services

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

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

The problem must be because of:

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

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

7.4.21 Medication Administered by Provider, Treatment/Infusion Center or Home Infusion Therapy

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

Some medications will not be covered unless you use a preferred treatment center. The treatment program may include office visits, testing, a stay at the treatment center and the

medication. Sometimes travel expenses may be included. Treatment must be prior authorized (see section 6.1).

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

See section 7.4.18 for more information about infusion therapy. Self-administered medications are not covered under this benefit (see section 7.6.6). See section 7.6 for pharmacy benefits.

7.4.22 Nonprescription Enteral Formula for Home Use

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

7.4.23 Nutritional Therapy

Dietary or nutritional therapy is covered for certain conditions (but not for obesity). Nutritional therapy for eating disorders must be authorized after the first 5 visits. Preventive nutritional therapy required under the Affordable Care Act is covered under the preventive care benefit. Also see diabetes services (section 7.4.7) and inborn errors of metabolism (section 7.4.17).

7.4.24 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 medical doctors are specialist office visits unless we have credentialed the naturopathic physician as a primary care provider.

7.4.25 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.

7.4.26 Pre-admission Testing

Preadmission testing is covered when ordered by your professional provider.

7.4.27 Rehabilitation & Habilitation

Covered rehabilitation and habilitation services are:

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

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

a. Medically necessary
b. Part of your professional provider's written treatment plan to improve and restore lost function following illness or injury

c. Inpatient services are in a hospital or other inpatient facility that specializes in such care

Covered outpatient rehabilitative and habilitative services have separate annual limits. These limits do not apply to medically necessary cardiac or pulmonary rehabilitation or services for behavioral health. A session is one visit. Only one session of each type of outpatient physical, occupational or speech therapy is covered in one day.

Rehabilitative services restore or improve an ability you have lost function because of a medical condition. Habilitative services are used to form skills that you never developed due to a medical condition.

Outpatient rehabilitative services are short term. Your condition is expected to improve in a reasonable and generally predictable period of time. Therapy you get to prevent a condition or function from getting worse or to maintain your level of functioning without documented improvement is maintenance therapy and is not covered. Recreational or educational therapy, educational testing or training, non-medical self-help or training, or animal therapy are not covered.

7.4.28 Skilled Nursing Facility Care

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

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

Exclusions

These skilled nursing facility charges are not covered:

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

7.4.29 Spinal Manipulation

A limited number of visits are covered each year. Other services you may get at a spinal manipulation visit, such as office visits, lab and diagnostic x-rays, or physical therapy, are not covered under this benefit. They are paid under the Plan's standard benefit for the type of service. If the copayment for spinal manipulation and related services are different, you will have to pay the highest copayment at any one visit with the same provider. You will also have to pay any coinsurance that applies. Office visits by chiropractors are specialist office visits.

7.4.30 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 applies to the following services:

a. Primary surgeon

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

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.

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 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. This includes services to treat a covered mental health condition, such as gender dysphoria.

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 7.4.11) or following 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
d. Treatment of physical complications of the mastectomy, including lymphedemas
e. Inpatient care related to the mastectomy and post-mastectomy services

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

7.4.31 Therapeutic Injections

Administrative services for therapeutic injections, such as allergy shots, are covered when you get them in a professional provider's office. When you can get similar results with self-administered medications at home, the administrative services for therapeutic injections by your provider are not covered. Vitamin and mineral injections are not covered unless they are medically necessary to treat a specific medical condition. More information is in sections 7.4.21 and 7.6.6.

7.4.32 Therapeutic Radiology and Chemotherapy

Covered expenses include:

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

7.4.33 Transplants

A transplant is a procedure or a 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. Your provider should get prior authorization as soon as possible after you know you may be a possible transplant candidate. This section's requirements do not apply to collecting and/or transfusing blood or blood products (see section 7.4.30).

Benefits for transplants are limited as follows:

a. If a transplant procedure is performed at a facility other than a Center of Excellence, the deductible and coinsurance will not accumulate toward the out-of-pocket maximum amount. **Note:** Your coinsurance will apply to services not performed at a Center of Excellence even if you have met the out-of-pocket maximum.
b. Donor costs are covered as follows:
    i. If you are the recipient or self-donor, donor costs related to a covered transplant are covered. If the donor is also enrolled on the policy, expenses resulting from complications and unforeseen effects of the donation, 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.
c. Travel and housing expenses for the recipient and one caregiver are covered up to a maximum per transplant.
d. Professional provider transplant services are paid according to the benefits for professional providers.
e. Immunosuppressive drugs you get during a hospital stay are paid as a medical supply. Outpatient oral and self-injectable prescription medications for transplant related services are paid under the Pharmacy Prescription benefit (section 7.6).
f. Travel and housing expenses for the recipient and one caregiver are covered up to a maximum per transplant
g. 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.

Donor costs are the covered expenses 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.

7.4.34 Virtual Care Visits (Telemedicine)

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

A virtual visit is covered if:

a. The covered services can be safely and effectively provided in a virtual care visit

b. The technology used meets all state and federal standards for privacy and security of protected health information.

Virtual care visits using the preferred vendor are covered at no cost sharing (see Section 3).

7.4.35 Pediatric Vision Services

If you are under age 19, we cover the following services once per year. This coverage ends at 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 an in-network vision care provider and arrange for vision services. Some vision services may require prior authorization.

If you are eligible for vision plan benefits, VSP will provide benefit authorization directly to the in-network doctor. When contacting an in-network doctor directly, you must identify yourself as a VSP member so the doctor will obtain benefit authorization from VSP. If you receive services from an in-network doctor without such benefit authorization or obtain services from an out-of-network provider, 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 an out-of-network provider.

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

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

7.4.36 Adult Vision Exam

For members age 19 and older, the Plan covers one complete eye exam annually, including the charge for refraction.

Members can visit www.vsp.com or call 800-877-7195 to choose a vision care provider and arrange for a vision exam. For members who are eligible for a vision exam, VSP will provide benefit authorization directly to the provider. Should members receive services from an in-network vision care provider without such benefit authorization they are responsible for payment in full to the provider and will need to submit a request for reimbursement by completing the member reimbursement claim form, which is available by visiting www.vsp.com or calling 800-877-7195.

7.5 MATERNITY CARE

Pregnancy care, childbirth and related conditions are covered when you get the care from a professional provider. Midwives are not considered professional providers unless they are licensed and certified.

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

If you have a home birth, the only expenses that are covered are the fees billed by a professional provider. Other home birth charges, such as travel and portable hot tubs, are not covered. Supportive services, such as physical, emotional and information support to you before, during and after birth and during the postpartum period, are not covered.

7.5.1 Breastfeeding Support

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

7.5.2 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.

7.5.3 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.

7.5.4 Involuntary Complications of Pregnancy

Treatment for involuntary complications of pregnancy, including , but not be limited to, puerperal infection, eclampsia, cesarean section delivery, ectopic pregnancy, and toxemia, are covered.

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. Nursery care includes one in-nursery physician's visit of well-newborn infant (preventive health exam). This is covered at no cost sharing when your provider is in-network. There is no deductible for routine nursery care. Additional visits are covered at the hospital visit benefit level. Nursery care is covered under the newborn's own coverage and is routine while you are in the hospital and receiving maternity benefits.
d. Other hospital services and supplies When medically necessary for treatment and ordinarily provided by a hospital
e. Take-home prescription drugs are limited to a 3-day supply at the same benefit level as for hospitalization

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

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

Brand Substitution Is a policy that applies to brand medications filled at the pharmacy when a generic option is available. If you or your treating professional provider do not want the available generic, you may have to pay the nonpreferred cost sharing plus the difference in cost between the generic and brand medication.

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 find they do not have significant therapeutic advantage over their preferred alternative(s). These medications generally have safe and effective options available under the Value, Select and/or Preferred tiers.

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

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

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

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

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

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

7.6.2 Covered Medication Supply

The following medication and supplies are covered when they have been prescribed for you:

a. A prescription medication that is medically necessary to treat a medical condition
b. Compounded medications that have at least one covered medication as the main ingredient

c. Insulin and diabetic supplies including insulin syringes, needles and lancets, test strips, glucometers and continuous glucose monitors. You must have a prescription and use a preferred manufacturer
d. Certain prescribed preventive medications required under the Affordable Care Act
e. Medications to treat tobacco dependence, including OTC nicotine patches, gum or lozenges. You must have a prescription. If you use an in-network retail pharmacy, they are covered with no cost sharing as required under the Affordable Care Act
f. Contraceptive medications and devices for birth control (section 7.3.2) and for medical conditions covered under the Plan. You can get up to a 3-month supply the first time you use the medication and up to a 6-month supply after that. Ask Customer Service how to get a 6-month supply.
g. Certain immunizations and related administration fees are covered with no cost sharing at in-network retail pharmacies (such as flu, pneumonia and shingles vaccines)

Certain prescription medications and/or quantities of prescription medications may need to be prior authorized (see section 6.1). You must get specialty medications from a Moda-designated specialty pharmacy.

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

You or your professional provider can ask for a medication that is not on the formulary through your Member Dashboard 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 your 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 generic substitution, plan limitations or exclusions.

7.6.3 90-Day Supply at Participating Retail Pharmacies

You may buy a 90-day supply from participating retail pharmacies. Not all medications are eligible for a 90-day supply. All standard benefit and administrative provisions (such as prior authorization and step therapy) apply. Search for participating pharmacies using your Member Dashboard. Participating pharmacies will say "3 months" under the Day Supply column in their details.

7.6.4 Mail Order Pharmacy

You can choose to fill prescriptions for covered medications through a Moda-designated mail order pharmacy. Get a mail order pharmacy form on your Member Dashboard or by contacting Customer Service. You may also fill prescriptions for covered medications through a mail order pharmacy not contracted with us, if that mail order pharmacy is registered and agrees to dispense covered medications according to the same terms and conditions for our designated mail order pharmacies.

7.6.5 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 specialty pharmacy. Find information 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 buy specialty medications at a non-Moda-designated specialty pharmacy, prior authorization is required. 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.

7.6.6 Self-Administered Medication

All self-administered medications follow all of the prescription medication requirements of section 7.6. This includes the specialty medication requirements (section 7.6.5) when you get a self-administered specialty medication. Self-administered injectable medications are not covered if you get them in a provider's office, clinic or facility.

7.6.7 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.

We will make an exception to the step therapy requirement if:

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

7.6.8 Limitations

a. New FDA approved medications will be reviewed. We may have coverage requirements or limits. You or your prescriber can ask for a medical necessity evaluation if we do not cover a newly approved medication during the review period
b. If you get a brand medication when a generic equivalent is available, you may have to pay the difference in cost between the generic and brand medication. Additional costs because of brand substitution do not count toward your out-of-pocket maximum.
c. We may prior authorize certain brand medications for a specific amount of time or until a generic medication becomes available, whichever comes first. When a generic medication becomes available during the authorized period, the brand medication is no

longer covered. You can get the generic medication without a new prescription or authorization.

d. You may not bypass the Plan's requirements (such as step therapy, prior authorization) by starting treatment with a medication, whether by using free samples or otherwise.
e. Some specialty medications may be limited to a 2-week supply
f. Medications with dosing intervals greater than the Plan's maximum day supply will have an increased copayment to match the day supply.
g. Medications you buy outside the United States and its territories are only covered in emergency and urgent care situations
h. You may ask to have your 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.

7.6.9 Exclusions

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

a. **Devices.** Including but not limited to therapeutic devices and appliances. Information for contraceptive devices is in section 7.6.2 and for other devices in section 7.4.9
b. **Pharmacies excluded from the network**. Medications from pharmacies that have been excluded from the network due to non-compliance with fraud, waste or abuse.
c. **Foreign Medication Claims.** Medications you buy from non-U.S. mail order or online pharmacies or U.S. mail or online pharmacies acting as agents of non-U.S. pharmacies
d. **Hair Growth Medications**
e. **Immunization Agents for Travel.** Except as required under the Affordable Care Act
f. **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
g. **Medication Administration.** A charge to administer or inject a medication, except for immunizations or contraceptives at retail pharmacies
h. **Medications Covered Under Another Benefit.** Such as medications covered under 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.
j. **Non-Covered Condition.** A medication prescribed for reasons other than to treat a covered medical condition
k. **Nutritional Supplements and Medical Foods**
l. **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.
m. **Over the Counter (OTC) Medications** and certain prescription medications that have an OTC option, except for contraceptives or those treating tobacco dependence
n. **Repackaged Medications**
o. **Replacement Medications and/or Supplies**
p. **Vitamins and Minerals.** Except as required by law
q. **Weight Loss Medications**

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 an in-network provider, or they relate to a covered condition. Treatment of a complication or consequence that happens because of an exclusion is not covered. Except, treatment of an emergency medical condition is always covered.

Abortion
Except the mother's life is at risk or the pregnancy is a result of rape or incest

Acupuncture

Benefits Not Stated
Services and supplies not specifically described in this policy as covered expenses, unless required under federal or state law

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

Charges Over the Maximum Plan Allowance

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-confirming surgery is covered if medically necessary and not specifically excluded (see sections 7.4.30 and 7.4.11).

Court Ordered Sex Offender Treatment

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

Dental Examinations and Treatment; Orthodontia
Except services described in section 7.4.6

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 games (software)
b. Psychoanalysis or psychotherapy as part of a training or educational program, regardless of your diagnosis or symptoms

Experimental or Investigational Procedures
Expenses due to experimental or investigational procedures. Includes related expenses, even if they would be covered in other (non-experimental, non-investigational) situations (see definition of experimental/investigational in Section 11)

Faith Healing

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

Hearing Services
Except as described in section 7.4.12

Home Birth or Delivery
Charges other than the professional services billed by your professional provider, including travel, portable hot tubs and transportation of equipment

Homeopathic Treatment and Supplies

Horse-Assisted or Animal Therapy

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

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 you are in the custody of any state or federal law enforcement authorities or while in jail or prison

Massage or Massage Therapy

Missed Appointments

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

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

Non-Therapeutic Counseling

Including legal, financial, vocational, spiritual and pastoral counseling

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

Nutritional Counseling
Except as described in section 7.4.23

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 you 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 7.4.9

Orthognathic Surgery
Including associated services and supplies. Except when medically necessary to repair an accidental injury or for treatment of cancer.

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

Physical Exercise Programs
Programs, videos and exercise equipment

Private Nursing Services

Professional Athletic Activities
Diagnosis, treatment and rehabilitation services for injuries you get while you are practicing for or participating in a professional or semi-professional athletic contest or event. These are events or activities you are paid or sponsored to do full-time or part-time. Semi-professional means you are engaging in an activity for pay or gain but not as a full-time occupation.

Recreation Related Services and Equipment
Recreation therapy and equipment used mainly in recreational activities

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 benign 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

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

Self-Administered Medications
Including oral and self-injectable when you get them directly from a physician's office, facility or clinic instead of through the pharmacy prescription medication or anticancer benefits (sections 7.6.6 and 7.4.1)

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

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

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

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 unless prohibited by law.

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

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

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 Education
Including:

a. Level 0.5 education-only programs
b. Education-only, court mandated anger management classes
c. Family education or support groups, except as required under the Affordable Care Act

Taxes, Fees and Interest
Except as required by law

Telehealth
Except telemedicine as specifically described in section 7.4.34

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

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

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

Transportation
Except medically necessary ambulance transport

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

Treatment After Coverage Ends
Except for covered hearing aids ordered before your coverage ends and you get them no more than 90 days after the policy ends or extension of benefits under section 10.11.1 or 10.11.2

Treatment Before Coverage Begins
Including services and supplies for an admission to a hospital, skilled nursing facility or other facility that began before your coverage in this policy began. We will provide coverage only for those covered expenses incurred on or after your effective date under the policy.

Treatment Not Medically Necessary
Including services or supplies that do not meet our medical necessity criteria or are:

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

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

Vision Care
Including eye exams, the fitting, provision or replacement of eyeglasses or contact lenses, and any charges for orthoptics, vitamin therapy, low vision therapy, eye exercises or fundus photography, except where specifically covered under the policy. See section 7.4.35 for pediatric vision services, section 7.4.36 for adult vision exam and section 7.4.7 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, 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

What to know about sending us a claim:

a. We must receive your claim (also known as proof of loss) no more than 12 months after the date of service. Written proof of loss must be sent to us in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within 90 days after the termination of the period for which we are liable and in case of claim for any other loss within 90 days after the date of such loss. Failure to send such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is sent as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.
b. We will not pay any claims we do not receive on time. The only exception is in the absence of legal capacity
c. We do not always pay claims in the same order you received the services. This may affect how your cost sharing is applied to claims. For example, a deductible may not be applied to the first date you were seen in a benefit year if we pay a later date of service first
d. We may pay benefits to you, to the provider or to both of you

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

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

9.1.1 Notice of Claim and Claim Forms

In general, your in-network providers submit claims for you. If you need to submit claims, you can let us know you have a claim (also known as notice of claim) and we will send you a claim form. You may download a claim form directly from our website.

Written notice of any loss resulting in a claim being filed with this benefit must be given to us within 20 days after the loss occurs, or as soon as reasonably possible.

When notice of claim is received, we will send you the claim forms for filing proof of loss. If the forms are not received within 15 days, you can send us written proof of loss without waiting for the forms.

9.1.2 How to Send Us Claims

Sometimes you will have to pay a provider up front.

When you are billed by the hospital or professional provider directly, send us a copy of the bill (see section 2.1 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. **Vision service**: a member who has vision services provided by an in-network provider without benefit authorization will need to submit a request for reimbursement by completing the member reimbursement claim form, which is available by visiting www.vsp.com or calling 800-877-7195
d. **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)
    iii. Proof of payment. This can be a credit card/bank statement or cancelled check

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

9.1.3 Prescription Medication Claims

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

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

9.1.4 Timely Payment of Claims

We will pay for any loss upon receipt of due written proof of loss.

For claims that do not require additional information, we will pay or deny the claim, and an Explanation of Benefits (EOB) will be sent to you within 30 days from the date we receive 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 processing your claim and send an EOB to you no later than 15 days after receiving the information.

9.1.5 Explanation of Benefits (EOB)

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

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

9.1.6 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.

9.2 COMPLAINTS, APPEALS & EXTERNAL REVIEW

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

9.2.1 Time Limit for Submitting Appeals

You have **180 days** from the date you receive an adverse benefit determination to send us your appeal. If your appeal is not submitted on time, you will lose the right to any appeal.

You can fill out an appeal form (in your Member Dashboard under Resources), or send us a letter including all of the identifying information from the appeal form (see "If I am not satisfied…" in section 12.2. Describe what happened and what outcome you are hoping for. Including medical records or other documentation that will help us investigate your appeal.

9.2.2 Definitions

For purposes of section 9.2, the following definitions apply:

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

a. Rescission of coverage (section 10.9.7)
b. Eligibility to participate in the policy
c. Network exclusion, annual benefit limit or other limitation on otherwise covered services
d. Utilization review (described below)
e. Limitations or exclusions described in Section 7 and Section 8, including a decision that an item or service is experimental or investigational or not medically necessary

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

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

Complaint is an expression of dissatisfaction about a specific problem you have had or about a decision by us or someone acting for us, or a provider. It includes a request to solve the problem or change the decision. Asking for information or clarification about the policy is not a complaint.

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

a. Seriously risk your life or health or ability to regain maximum function

b. Would subject you to severe pain that cannot be managed without the requested care or treatment. A physician with knowledge of your medical condition decides this.

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

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

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

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

9.2.3 The Review Process

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 have the right to appeal before a panel via virtual conferencing. You may find this form on modahealth.com/idaho. Contact Customer Service for help assigning your representative.

How Appeals Work

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

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

Expedited Appeals

Appeals can have a faster review upon request. Review of appeals that meet the criteria to be expedited will be finished no later than 72 hours after we have received the appeal.

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

Special Circumstances

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

The timelines for reviewing your appeal do not apply if:

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

9.2.4 External Review

You may ask to have your appeal reviewed by an independent review organization (IRO) appointed by the Idaho Department of Insurance.

YOUR RIGHT TO AN INDEPENDENT EXTERNAL REVIEW

Please read this notice carefully. It describes a procedure for review of a disputed health claim by a qualified professional who has no affiliation with your health plan. If you request an independent external review of your claim, the decision made by the independent reviewer will be binding and final on the health carrier. You will have the right to further review of your claim by a court, arbitrator, mediator or other dispute resolution entity only if your plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA), as more fully explained below under "Binding Nature of the External Review Decision."

If we issue a final adverse benefit determination of your request to provide or pay for a health care service or supply, you may have the right to have our decision reviewed by health care professionals who have no association with us. You have this right only if our denial decision involved:

The medical necessity, appropriateness, health care setting, level of care, or effectiveness of your health care service or supply, or
Our determination your health care service or supply was investigational.

You must first exhaust our internal grievance and appeal process. Exhaustion of that process includes completing all levels of appeal, or unless you requested or agreed to a delay, our failure to respond to a standard appeal within 35 days in writing or to an urgent appeal within three business days of the date you filed your appeal. We may also agree to waive the exhaustion requirement for an external review request. You may file for an internal urgent appeal with us and for an expedited external review with the Idaho Department of Insurance at the same time if your request qualifies as an "urgent care request" defined below.

You may submit a written request for an external review to:

Idaho Department of Insurance
ATTN: External Review
700 W State St., 3rd Floor
Boise ID 83720-0043

For more information and for an external review request form:

See the department's website at http://www.doi.idaho.gov, or
Call the department's telephone number, 208 334-4250, or toll-free in Idaho, 1-800-721-3272.

You may represent yourself in your request or you may name another person, including your treating health care provider, to act as your authorized representative for your request. If you want someone else to represent you, you must include a signed "Appointment of an Authorized Representative" form with your request.

Your written external review request to the Department of Insurance must include a completed form authorizing the release of any of your medical records the independent review organization may require to reach a decision on the external review, including any judicial review of the external review decision pursuant to ERISA, if applicable. The department will not act on an external review request without your completed authorization form.

If your request qualifies for external review, our final adverse benefit determination will be reviewed by an independent review organization selected by the department. We will pay the costs of the review.

Standard External Review Request: You must file your written external review request with the department within four months after the date we issue a final notice of denial.

1. Within seven days after the department receives your request, the department will send a copy to us.
2. Within 14 days after we receive your request from the department, we will review your request for eligibility. Within five business days after we complete that review, we will notify you and the department in writing if your request is eligible or what additional information is needed. If we deny your eligibility for review, you may appeal that determination to the department.
3. If your request is eligible for review, the department will assign an independent review organization to your review within seven days of receipt of our notice. The department will also notify you in writing.
4. Within seven days of the date you receive the department's notice of assignment to an independent review organization, you may submit any additional information in writing to the independent review organization that you want the organization to consider in its review.
5. The independent review organization must provide written notice of its decision to you, to us and to the department within 42 days after receipt of an external review request.

Expedited External Review Request: You may file a written "urgent care request" with the department for an expedited external review of a pre-service or concurrent service denial. You may file for an internal urgent appeal with us and for an expedited external review with the department at the same time.

"Urgent care request" means a claim relating to an admission, availability of care, continued stay or health care service for which you received emergency services but has not been discharged from a facility, or any pre-service or concurrent care claim for medical care or treatment for which application of the time periods for making a regular external review determination:

1. Could seriously jeopardize your life or health or your ability to regain maximum function;
2. In the opinion of the treating health care professional with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the disputed care or treatment; or
3. The treatment would be significantly less effective if not promptly initiated.

The department will send your request to us. We will determine, no later than the second full business day, if your request is eligible for review. We will notify you and the department no later than one business day after our decision if your request is eligible. If we deny your eligibility for review, you may appeal that determination to the department.

If your request is eligible for review, the department will assign an independent review organization to your review upon receipt of our notice. The department will also notify you. The independent review organization must provide notice of its decision to you, to us and to the department within 72 hours after the date of receipt of the external review request. The independent review organization must provide written confirmation of its decision within 48 hours of notice of its decision. If the decision reverses our denial, we will notify you and the department of our intent to pay the covered benefit as soon as reasonably practicable, but not later than one business day after receiving notice of the decision.

Binding Nature of the External Review Decision: If your plan is subject to federal ERISA laws (generally, any plan offered through an employer to its employees), the external review decision by the independent review organization will be final and binding on us. You may have additional review rights provided under federal ERISA laws.

If your plan is not subject to ERISA requirements, the external review decision by the independent review organization will be final and binding on both you and us. **This means that if you elect to request external review, you will be bound by the decision of the independent review organization. You will not have any further opportunity for review of our denial after the independent review organization issues its final decision.** If you choose not to use the external review process, other options for resolving a disputed claim may include mediation, arbitration or filing an action in court.

Under Idaho law, the independent review organization is immune from any claim relating to its opinion rendered or acts or omissions performed within the scope of its duties unless performed in bad faith or involving gross negligence.

9.2.5 Complaints

Submit your complaint in writing within 30 days from the date of the problem or claim. We will review complaints about:

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

We will finish reviewing your complaint within 30 days. If we need more time, we will tell send you a letter letting you know 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 Idaho Department of Insurance.

Phone:	208-334-4250 or toll-free 800-721-3272
Mail:	700 W State St., 3rd Floor, PO Box 83720, Boise, ID 83720-0043
Internet:	doi.idaho.gov
email:	doi.idaho.gov/contact-doi/?id=31

9.3 CONTINUITY OF CARE

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

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

Continuity of care is not automatic. You must request continuity of care from us.

Continuing care patients mean persons who meet 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

In addition:
a. You must be a continuing care patient.
b. Your provider must agree to follow the requirements of their most recent medical services contract with us, and to accept the contractual reimbursement applicable at the time the contract ended.

Continuity of care 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

Continuity of care is not available if:
a. You are no longer covered by this policy
b. The subscriber ends the policy
c. The provider has moved out of the service area
d. The provider cannot continue to care for patients for other reasons
e. The contract with the provider has ended for reasons related to quality of care and they have finished any appeal process

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, and then any other plans pay. The policy follows the order of benefit determination rules in the Idaho Administrative Procedures Act. These rules decide which plan is primary and pays a claim for benefits first. (For coordination with Medicare, see section 9.4.2)

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

9.4.1.1 When this Plan Pays First

When another plan does not have a COB provision, that plan is primary. When another plan does have a COB provision, the first of the following rules that applies will govern:

a. **Non-dependent/Dependent.** If a plan covers the member as other than a dependent (e.g., an employee, member of an organization, primary insured, or retiree), then that plan will determine its benefits before a plan that covers the member as a dependent. However, if the member is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the member as a dependent and primary to the plan covering the member as other than a dependent (e.g., a retired employee), then the order of benefits between the 2 plans is reversed.
b. **Dependent Child/Parents Married or Living Together.** If the member is a dependent child whose parents are married or living together whether or not they have ever been married, the plan of the parent whose birthday falls earlier in the calendar year is the primary plan. If both parents' birthdays are on the same day, the plan that has covered the parent the longest is the primary plan.
c. **Dependent Child/Parents Separated or Divorced or Not Living Together.** If the member is a dependent child of divorced or separated parents, or parents not living together whether or not they have been married, then the following rules apply:
    i. If a court decree states that one of the parents is responsible for the healthcare expenses of the child, and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to policy year beginning after the plan is given notice of the court decree.
    ii. If a court decree states that both parents are responsible for the healthcare expenses of the child, or that the parents have joint custody without specifying that one parent is responsible, the birthday rule described above applies.
    iii. If there is not a court decree allocating responsibility for the child's healthcare expenses, the order of benefits is as follows: The plan covering the
        A. Custodial parent
        B. Spouse or domestic partner of the custodial parent
        C. Non-custodial parent
        D. Spouse or domestic partner of the non-custodial parent
d. **Dependent Child Covered by Individual Other than Parent.** For a dependent child covered under more than one plan of persons who are not the parents of the child, the

first applicable provision (b. or c.) above shall determine the order of benefits as if those persons were the parents of the child.

e. **Dependent Child Covered by Parent and Spouse/Domestic Partner.** For a dependent child covered under the plans of both a parent and a spouse or domestic partner, the length of coverage provision below shall determine the order of benefits. If coverage under either or both parents' plans and the spouse's/domestic partner's plan began on the same day, the birthday rule will apply.
f. **Active/Retired or Laid Off Employee.** The plan that covers a member as an active employee (i.e., one who is neither laid off nor retired) or as that employee's dependent determines its benefits before those of a plan that covers the member as a laid off or retired employee or as that employee's dependent. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of the benefits, this rule is ignored.
g. **COBRA or State Continuation Coverage.** If a member whose coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering that member as an employee, member of an organization, primary insured, or retiree or as a dependent of the same, is the primary plan and the COBRA or other continuation coverage is the secondary plan. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of the benefits, this rule is ignored.
h. **Longer/Shorter Length of Coverage.** The plan that covered a member longer is the primary plan and the plan that covered the member for the shorter period of time is the secondary plan.
i. **None of the Above.** If the preceding rules do not determine the order of benefits, the allowable expenses shall be shared equally between the plans. In addition, this Plan will not pay more than it would have paid if it had been the primary plan.

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 credit any amounts to the deductible that would have been applied if you did not have other coverage.
c. We will reduce the benefits we pay so that payments from all plans are not more than 100% of the total allowable expense.
d. If the primary plan did not cover an expense because you did not follow that plan's rules, we will not cover that expense either.

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

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

9.4.1.3 Definitions

For purposes of section 9.4.1, the following definitions apply:

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:

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

The following are examples of expenses that are not allowable expenses.

a. The difference between the cost of a semi-private hospital room and a private hospital room is not a covered expense, unless one of the plans provides coverage for private hospital room expenses.
b. If you are covered by 2 or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an allowable expense.
c. If you are covered by 2 or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an allowable expense.
d. If you are covered by one plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan's payment arrangement shall be the allowable expense for all plans. However, if the provider has contracted with the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the allowable expense used by the secondary plan to determine its benefits.
e. The amount of any benefit reduction by the primary plan because a member has failed to comply with the plan provisions is not an allowable expense. Examples of these types of plan provisions include second surgical opinions, prior authorization of admissions, and preferred provider arrangements.

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

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

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

a. Group or nongroup insurance contracts and subscriber contracts
b. HMO (health maintenance organization) coverage
c. Closed panel plans
d. Medical benefits under group or individual automobile contracts
e. Medical care components of group long-term care contracts, such as skilled nursing care
f. Medicare or other government programs, other than Medicaid, and any other coverage required or provided by law
g. Other arrangements of insured or uninsured 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 type coverage
c. Specified disease or specified accident coverage
d. Limited benefit health coverage as defined by state law
e. Benefits for non-medical components of long-term care policies
f. Medicare supplement policies
g. Medicaid policies
h. Coverage under other federal governmental plans, unless permitted by law

9.4.2 Coordination with Medicare

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

9.4.3 Third Party Liability

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

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

You agree to do whatever is necessary to fully secure and protect 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 actions that will help us recover costs from a third party.

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

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

c. A proportionate share of reasonable attorney fees may be subtracted from our recovery.

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

e. If it is reasonable to expect that you will have future expenses for which we 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 we advance 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 (see section 9.4.3). 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 us for covered services related to conception, pregnancy, delivery and postpartum care that you receive in connection with the surrogacy agreement. By accepting services, you give 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

You cannot be covered by more than one Moda Health Individual medical policy at a time. If you are already enrolled in Medicare, you cannot enroll on this policy.

You are not eligible to enroll if your main reason for living in the service area is to get health coverage or another temporary reason such as getting treatment. Living in a residential care facility to receive treatment does not meet the residency requirement.

10.1 CHILD ONLY POLICY

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.

10.2 SUBSCRIBER

To be eligible and stay eligible for coverage, you must live in the service area for a continuous 6-month period and intending to live in the service area permanently or indefinitely. If You intend to reside in the service area, you may apply, but you would not be eligible for coverage until you physically reside in the service area. 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.

10.3 DEPENDENTS

A subscriber's legal spouse or domestic partner (as defined in Section 11) is eligible for coverage. If a subscriber marries or enters a domestic partnership while enrolled in this policy, the spouse or domestic partner and their children may be added to this policy. Coverage begins on the first day of the month after your application is received.

Eligible children are eligible until their 26th birthday. Foster children are eligible only while legally a foster child.

On this policy, eligible children are:

a. The biological, adopted or foster child of the subscriber or the subscriber's eligible spouse or domestic partner
b. Children placed for adoption with the subscriber or the subscriber's eligible spouse or domestic partner
c. The subscriber's newborn child for the first 31 days of the newborn's life
d. Children for whom the subscriber is required to provide coverage by a legal qualified medical child support order (QMCSO)
e. Children related to the subscriber and the subscriber is their legal guardian

Eligible newborn child is eligible from birth and coverage begins that day. Eligible adopted child, foster child or child placed for adoption is eligible on the date of placement. Their coverage begins on the date of adoption or placement. You must provide proof of legal guardianship to cover the subscriber's grandchild after the first 31 days from birth. See section 10.4 to add your new child.

Children with Disabilities
An enrolled child who is not married and has a disability that makes them physically or mentally incapable of self-support is eligible for coverage even when they are over 26 years old. Submit written information from the child's physician showing that the child has an ongoing disability that does not allow them to work to support themself and the child is chiefly dependent on the subscriber for support. To make sure there is not a gap in coverage, we need this information at least 31 days before their 26th birthday. We may ask for more information, such as tax and guardianship information, to confirm the child is eligible for this extended coverage. We will review eligibility from time to time unless the disability is permanent.

10.4 NEW DEPENDENTS

A new dependent may cause your premium to go up. Any premium changes will apply from the date coverage is effective. If you do not submit an application and/or payment when required, the new dependent will not be covered.

To add a new dependent to your coverage, submit:

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

You must apply within 31 days of the new spouse or domestic partner (60 days for the newborn, adopted child or child placed for adoption) becoming eligible. If you do not, you will have to wait until the next open enrollment period. You need to inform us if you are adding or dropping family members from your coverage, even if it does not change your premiums.

10.5 OPEN ENROLLMENT PERIOD

Persons can apply for coverage during the open enrollment period. Open enrollment is usually from October 15 to December 15 each year. These dates may be different in future years. Coverage begins on the date the policy renews.

10.6 SPECIAL ENROLLMENT

You can apply for coverage or enroll in another individual policy outside of open enrollment when you have a qualifying event.

For these qualifying events, apply no more than 60 days before or after the event occurs:

a. Loss of minimum essential coverage because you are no longer eligible for your current plan

b. End of a non-calendar year plan, including an individual coverage HRA (ICHRA) or qualified small employer HRA (QSEHRA) and you choose not to renew
c. End of an Idaho Enhanced Short Term Plan (ESTP) coverage after 36 months of continuous enrollment or loss of the dependent eligibility in the ESTP
d. You move permanently to a new location with access to new qualified health plans (QHPs)
e. Employer premium contributions or government subsidies for your COBRA continuation coverage end
f. You become newly eligible for advance payments of the premium tax credit because you are on a group plan and have become ineligible for qualifying coverage on that plan
g. Gaining new access to an ICHRA or QSEHRA

For these qualifying events, you cannot apply in advance. You have up to 60 days after the event occurs to apply or enroll:

a. Gaining new dependents through marriage, domestic partner registration, birth, adoption, or placement for adoption or foster care
b. Child support order or other court order requires you to cover a dependent
c. Loss of coverage under Medicaid or a state child health plan, or due to military discharge
d. Gaining or losing your eligibility for cost sharing reductions or advanced payments of the premium tax credit
e. There is an error, misrepresentation or inaction by the Marketplace that causes you to become enrolled or disenrolled
f. The QHP in which you are enrolled is decertified, or there is adequate evidence that the QHP you are enrolled in violated a material provision

You are not eligible for special enrollment if you choose to end your coverage. This includes not paying your premium or if your coverage is rescinded.

Coverage generally begins on the 1st day of the month after your application is received, unless you choose a later month. If you apply on or before the loss of minimum essential coverage, coverage begins on the 1st of the month after the loss of coverage. When there is a court order or military discharge, coverage begins on the effective date of the order or the date of discharge. For a newborn child and an adopted child, coverage begins on the date of birth, date of adoption or date of placement.

10.7 PREMIUMS

The amount of premium you owe is shown on the declaration page that comes with this policy, or on any subsequent premium change notice.

10.7.1 Making Payments

We must receive your premium payments every month to keep your coverage active. You can pay by 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 payments. 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.

10.7.2 When Payments are Due

The initial premium payment must be made before the policy becomes effective. If you do not make the initial payment within the grace period, this policy never goes into effect.
All premium payments, including the initial payment to start coverage, 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. Your premium payment must be within 30 days of the due date.

If we do not receive your payment before the end of the grace period, this policy will end after an advance delinquency and termination notice (see section 10.9).

10.7.3 Changes in Amount of Premiums

Premiums can change without notice when your family composition or eligibility status changes or you move to a different county . The new premium amount 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 the premiums that affects all policyholders, we will tell you about this in writing 30 days before it takes effect. When the new premium is paid, this confirms that the subscriber accepts the change.

10.7.4 Unearned Premium

We will refund any premium that is collected but not used after cancellation of this policy.

10.8 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:

a. If you have not paid the required premiums. We will end the policy with an advance notice if we do not receive your premiums on time
b. For fraud or intentional misrepresentation by a member
c. When you are enrolled in Medicare
d. When we discontinue offering and/or renewing all of our individual health benefit plans in Idaho or in a specified service area within Idaho. We will send you a notice at least 180 days in advance of discontinuing a policy. When we discontinue coverage in the individual market, we will not write business in that market for a period of at least five years.
e. When we discontinue offering and/or renewing this policy in Idaho. We will send you a notice at least 90 days in advance of discontinuation of this policy.
f. When the Department of Insurance finds that renewal would:
    i. Not be in the best interests of our members
    ii. Impair Moda Health's ability to meet our contractual obligations

We may make changes (modify) to your individual health benefit plan when your coverage renews. The modification is not a discontinuation as described under bullet (d) or (e) above.

10.9 WHEN COVERAGE ENDS

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

10.9.1 Premium is Not Paid

If you do not pay your premiums before the end of the grace period, coverage ends on the last day of the month through which premiums are paid.

10.9.2 Subscriber Ends Coverage

A subscriber may end coverage for themself or any enrolled dependent, by giving us written notice 30 days in advance. Coverage ends on the last day of the month through which premiums are paid.

10.9.3 Death

If the subscriber dies, coverage for all enrolled dependents ends on the last day of that month. You may change to coverage in your own name by filing a written application with us and paying the required premium no more than 60 days after your eligibility under this policy ends.

10.9.4 Loss of Eligibility by Dependent

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

a. Coverage ends for an enrolled spouse or domestic partner on the last day of the month in which the marriage or partnership is legally ended (divorce, dissolution, annulment, etc.)
b. Coverage ends for an enrolled child on the last day of the month in which
    i. the child reaches age 26
    ii. stepchild relationship ends due to divorce or end of domestic partnership
    iii. legal guardianship or foster child relationship ends

You must tell us when a marriage, domestic partnership, guardianship or foster child relationship ends.

A former dependent may change to coverage under their own name by submitting a complete and signed application and paying the required premium no more than 60 days after eligibility under this policy ends.

10.9.5 Moving Out of the Service Area

Coverage will end if the subscriber no longer lives in the service area.

10.9.6 Reinstatement

If you do not pay any renewal premiums within the time allowed, a subsequent acceptance of premiums by us or by our authorized agent 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 you in writing of our 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 the subscriber and Moda Health shall have the same rights as they 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.

10.9.7 Rescission

Recission means canceling (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 are 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 have the right to keep any premiums paid as liquidated damages. You will have to repay any benefits that have been paid. We will tell you of a rescission 30 days before your coverage is cancelled.

10.9.8 We Refuse to Renew

Under certain circumstances (described in section 10.8), we can refuse to renew this policy at the end of any period for which premiums are paid.

10.10 TIME LIMIT ON CERTAIN DEFENSES

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

No claim for loss incurred or disability, commencing after two years from the date of issue of this policy, shall be reduced or denied on the grounds that a disease or physical condition, not excluded from coverage by name or specific description effective on the date of loss, had existed prior to the effective date of coverage of this policy.

10.11 EXTENSION OF BENEFITS

10.11.1 Extension of Benefits for Continuous Loss

Termination of this policy will not discontinue benefits for a continuous loss covered under this policy if your continuous loss commenced while the policy was in force. The extension of benefits for your continuous loss applies to a single inpatient stay where you are admitted prior to the policy termination date and your stay extends after the policy termination date, including any inpatient readmission that occurs within 30 days of your initial discharge. The extension of benefits for your continuous loss is also subject to any quantitative benefit limitations in the policy that you have not exhausted as of the termination date, such as day or visit limitations or maximum dollar amounts allotted for benefits.

10.11.2 Pregnancy Benefit Extension

If we cancel or otherwise fail to renew this policy, we shall provide for an extension of benefits for a pregnancy which started while this policy was in force and for which benefits would have been payable had this policy remained in force.

10.12 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 or domestic partner documentation, proof of residency and any other evidence necessary to document your eligibility on the policy.

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.

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

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

Birth Defect or **Congenital Anomaly** means a condition existing at or from birth that is a significant deviation from the common form or function of the body, whether caused by a hereditary or developmental defect or disease. The term significant deviation is defined to be a deviation which impairs the function of the body and includes, but not limited to, the conditions of cleft lip, cleft palate, webbed fingers or toes, sixth toes or fingers, or defects of metabolism, and other conditions that are medically diagnosed to be congenital anomalies.

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

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

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

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

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

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

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

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

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

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

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

Domestic Partnership Documentation is a signed document that attests the subscriber and one other eligible person meet the criteria in the document to be unregistered domestic partners.

Effective Date is the date coverage actually begins. During open enrollment, this is January 1st of the policy year. During special enrollments:

- For new policyholders, this is the first day of the month after we receive your application.
- For new dependents, it is the date of birth for a newborn child, the date of the adoption decree for an adopted child, the date of placement for a child placed for adoption or foster care and the date of the court appointment of a ward.
- For new spouses and domestic partners, or if you qualify due to loss of minimum essential coverage, it if 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 emergency services transport as well as healthcare items and services you get in an emergency department of a hospital. All related services routinely available to the emergency department to the extent they are required to stabilize a member, and further medical examination and treatment required to stabilize a member and within the capabilities of the staff and facilities available at the hospital, are included.

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

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

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

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

Implant is a material inserted or grafted into tissue.

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

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

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

MPA for out-of-network services is either a supplemental provider fee arrangement we may have in place or the amount calculated using any one of the following methods: a percentage of a Medicare equivalent allowable amount, a percentage of a Medicaid equivalent allowable amount, a percentile of fees commonly charged for a given procedure in a given area, the acquisition cost or a percentage of the billed charge.
MPA for emergency services you get out-of-network, out-of-network air ambulance, or out-of-network services in an in-network facility where you are not able to choose the provider is based on the median in-network rate. Otherwise, the MPA is the amount determined by federal or state guidelines.

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

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

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

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

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

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

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

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

Medically necessary care does not include custodial care.

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

See Treatment Not Medically Necessary in the General Exclusions (Section 8) for more information.

Member is a person whose application for individual health 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 psychologist associate
c. Psychiatric mental health nurse practitioner
d. Clinical social worker, mental health counselor, or marriage and family therapist

e. A program licensed, approved, established, maintained, contracted with or operated by the State of Idaho
f. A master social worker , master social worker independent, counselor associate or intern marriage and family therapy associate or intern, or psychology resident who is practicing under a board-approved supervision plan with a provider who is contracted and credentialed with Moda Health

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

Network is a group of providers who contract to provide healthcare you at negotiated rates. These groups are called Managed Care Organizations (MCOs), and provide in-network services in their specific service areas. See 5.1 for more information about networks. Covered medical expenses will be paid at a higher rate when an in-network provider is used, as shown in Section 3.

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

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

Placed or Placement for Adoption is the physical placement in the care of the adoptive subscriber or other member, or in those circumstances in which such physical placement is prevented due to the medical needs of the child requiring placement in a medical facility, it shall mean when the adoptive subscriber or other member signs an agreement for adoption of such child and signs an agreement assuming financial responsibility for such child.

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

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

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

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

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

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

Subscriber is the person in whose name the policy is issued after we accept that person's individual application.

SECTION 12. GENERAL PROVISIONS & LEGAL NOTICES

12.1 MEMBER DISCLOSURES

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

You have the right to:

a. Information about the policy 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)
    ii. a discussion of appropriate or medically necessary treatment options, no matter how much they cost or if they are covered
    iii. the right to refuse treatment and be informed of the possible medical result
    iv. filing a statement of wishes for treatment (i.e., an Advanced Directive), or giving someone else the right to make healthcare choices for you when you are unable to (Power of Attorney)
e. Privacy. Personal and medical information will only be used or shared as required or allowed by state and federal law
f. Appeal a decision or file a complaint about the policy, 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
i. Give or withdraw consent for electronic delivery of this policy and other notices from us

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.

You have the responsibility to:

a. Read this policy and make sure you understand it. You should call Customer Service if you have any questions
b. Treat all providers and their staff with courtesy and respect
c. Be on time for appointments, and call the office ahead of time if you will be late or need to cancel
d. Get regular health checkups and preventive services

e. Give your provider all the information they need to provide good healthcare to you
f. Participate in making decisions about your medical care and forming a treatment plan
g. Follow plans and instructions for care you have agreed to with your provider
h. Use urgent and emergency services appropriately
i. Show your medical ID card when seeking medical care
j. Tell providers about any other insurance policies that may provide coverage
k. Reimburse us from any third party payments you may receive
l. Provide information we need to correctly administer benefits and resolve any issues or concerns that may arise

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

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

What additional information about Moda Health is available?
The following documents are available free of charge by calling Customer Service:

i. An audited statement of financial condition including a balance sheet and a summary of receipts and disbursements
ii. A list of the providers currently participating in the plan, the providers who are accepting new patients, the addresses of primary care physicians and participating hospitals and the specialty of each physician and category of the other participating providers
iii. A statement as to whether the plan includes a limited formulary of medications, and a statement that the formulary will be made available to any prospective member or member upon request
iv. Our method of resolving member grievances
v. Qualifications of participating providers
vi. Description of the benefit package or packages and rates offered to each class of members

How can I participate in the development of your corporate policies and practices?
We welcome any suggestions to improve our health benefit plans or services. We have advisory committees to allow participation in the development of corporate policies and to provide feedback. You may contact us for more information.

12.2 GENERAL & MISCELLANEOUS

Entire Contract
This policy, including the endorsements and the attached papers, if any, constitute the entire contract of insurance. No change in this policy shall be valid until approved by our executive

officer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions.

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

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

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

Disclosure of Benefit Reduction
We will notify the subscriber if there is a material reduction in covered services or benefits no later than 30 days before the change is effective (more information is in section 10.8).

Payment of Claims
Losses covered by this benefit will be paid to you. Payment due at the time of your death will be paid to your estate.

Change of Beneficiary
You have the right to designate or change a beneficiary. The consent of the beneficiary or beneficiaries will not be requisite to surrender or assignment of this policy or to any change of beneficiary or beneficiaries, or to any other changes in this policy.

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.

Correction of Payments or Recovery of Benefits Paid by Mistake
If Moda Health mistakenly makes a payment for a member to which they are not entitled, or pays a person who is not eligible for payments at all, we have the right to recover the payment from the person paid or anyone else who benefited from it, including a provider. 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.

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 Moda Health delays or fails 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.

We will not be liable to any person or entity for the inability or failure to procure or provide the benefits in this handbook by reason of epidemic, disaster or other cause or condition beyond our control.

Physical Examinations and Autopsy
At our own expense, we have the right and opportunity to examine the member when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

Compliance with Federal & State Mandates
Moda Health provides benefits in accordance with the requirements of all applicable state and federal laws and as described in this policy. This includes compliance with federal mental health parity requirements and coverage of essential health benefits as defined by the Affordable Care Act, except that the policy does not provide the required pediatric dental coverage.

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 Idaho.

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 Idaho.

Legal Action
Any legal action arising out of, or related to, this Plan and filed against Moda Health by a member or any third party, must be filed in court no sooner than 60 days after the time the claim was submitted and no more than 3 years after the time the claim was submitted (see section 9.1). All internal levels of appeal under this Plan must be exhausted before filing a legal action in court.

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

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

SECTION 13. NOTICE OF YOUR RIGHTS UNDER NO SURPRISES ACT

This is a notice about your rights and protections against surprise medical bills.

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services
If you have an emergency medical condition and get emergency services from an out-of- network provider or facility, the most the provider or facility may bill you is your plan's in- network cost-sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center
When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.

- Your health plan generally must:

    - Cover emergency services without requiring you to get approval for services in advance (prior authorization).

    - Cover emergency services by out-of-network providers.

    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in- network provider or facility and show that amount in your explanation of benefits.

    - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

For help with surprise billing or more information about surprise medical bills, please contact us at 844-931-1775.

If you believe you've been wrongly billed, you may contact Idaho Department of Insurance by visiting the department's website at **doi.idaho.gov/nosurprises** or calling the Consumer Affairs section at 1-208-334-4319 or toll-free in Idaho at 1-800-721-3272.

Visit **doi.idaho.gov/nosurprises** for more information about your rights under this law.

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:

844-931-1775 (TDD/TTY 711)

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

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

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

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

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

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

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

Scott White coordinates our nondiscrimination work:

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

moda HEALTH

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　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。

ຊືນຊາບ: ຖ້າທ່ານເວົ້າພາສາ ລາວ,
ຈະມີບໍລິການຊ່ວຍດ້ານພາສາແບບບໍ່ເສຍຄ່າໃຫ້ທ່ານ.
ມີເຄື່ອງຊ່ວຍ ແລະ
ການບໍລິການແບບບໍ່ເສຍຄ່າທີ່ເໝາະສົມເພື່ອໃຫ້ຂໍ້ມູນໃນຮູບແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້. 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.

For help, call us directly at 844-931-1775
(En español: 888-756-7461)

P.O. Box 40384
Portland, OR 97240