2023

Alaska Individual Medical Policy

Moda Pioneer Alaska Standard Gold Plan
($2,000 Deductible Plan)

The subscriber may return this policy to Moda within 10 days of its delivery and have the premium paid refunded. In such a case, this policy shall then be voided from the beginning and Moda will hold the position as if no policy has been issued.

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

Scott Loftin
Senior Vice President

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

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

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SECTION 1. WELCOME

Moda Assurance Company, part of Moda Partners, Inc. is pleased to provide individual health coverage to members through the Individual Moda Pioneer Alaska Standard Gold Plan. This policy is designed to provide members with important information about the policy's benefits, limitations and procedures.

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

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

This policy is a description of members' individual health coverage. This policy may be changed or replaced without the agreement of any member other than the subscriber. The most current policy is on the Member Dashboard. All provisions are governed by this policy between the subscriber and Moda.

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

SECTION 2. MEMBER RESOURCES

2.1 CONTACT INFORMATION

Moda Website (log in to the **Member Dashboard**)
www.modahealth.com
Includes many helpful features, such as:

- Find Care (use to find a Tier 1 and Tier 2 provider)
- Prescription price check tool and formulary (medication cost estimates and benefit tiers)
- Prior authorization lists (services and supplies that may require authorization) www.modahealth.com/medical/referral

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

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

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

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

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

Virtual Care preferred vendor
CirrusMD
cirrusmd.com/modahealth

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

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

Telecommunications Relay Service for the hearing impaired
711

Moda
P.O. Box 40384
Portland, Oregon 97240

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

2.2 MEMBER ID CARD

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

2.3 NETWORKS AND TIER 2 PROVIDERS

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

Medical networks
Tier 1 Pioneer
Tier 2 First Choice in Alaska

Dental network
Delta Dental Premier

Pharmacy network
Navitus

Travel network
Aetna PPO

Vision network
VSP

2.4 CARE COORDINATION

2.4.1 Care Coordination

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

The Plan will coordinate access to a wide range of services spanning all levels of care, including medical travel support to a preferred provider (see 7.4.22). Coordinating these services helps members get the right services at the right time.

2.4.2 Disease Management & Health Coaching

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

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

Contact Disease Management and Health Coaching for more information.

2.4.3 Behavioral Health

Moda Behavioral Health provides specialty services for managing mental health and substance use disorder benefits to help members access care in the right place and contain costs. Behavioral Health Customer Service can help members locate Tier 1 and Tier 2 providers and understand their mental health and substance use disorder benefits.

2.5 OTHER RESOURCES

Additional member resources providing general information about the policy can be found in Section 12.

SECTION 3. SCHEDULE OF BENEFITS

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

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

The details of the actual benefits and the conditions, limitations and exclusions are contained in the sections that follow. Prior authorization may be required for some services (see section 6.1). Important terms are explained in Section 11.

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

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

Covered expenses for American Indians and Alaska Natives are at no cost sharing when provided directly through the Indian Health Service, Tribal Clinic, Urban Indian Clinic, or through referral under Contract Health Services.

	Tier 1 Benefits	**Tier 2 Benefits**	**Tier 3 Benefits**
Annual deductible per member	**$2,000** Tier 2 deductible applies	**$2,000** Tier 1 deductible applies	**$6,000**
Maximum annual deductible per family	**$4,000** Tier 2 deductible applies	**$4,000** Tier 1 deductible applies	**$12,000**
Annual out-of-pocket maximum per member	**$8,700** Tier 2 out-of-pocket maximum applies	**$8,700** Tier 1 out-of-pocket maximum applies	**$26,100**
Maximum annual out-of-pocket per family	**$17,400** Tier 2 out-of-pocket maximum applies	**$17,400** Tier 1 out-of-pocket maximum applies	**$52,200**

Services	Cost Sharing (Deductible applies unless noted differently)			Section in Handbook & Details
	Tier 1	**Tier 2**	**Tier 3**	
Urgent & Emergency Care				
Ambulance Transportation	25% Tier 1 deductible and out-of-pocket maximum apply			Section 7.2.1
Commercial Transportation	25%	25%	25%	Section 7.2.2 One-way for sudden, life-endangering medical condition. (Tier 1 deductible and out-of-pocket maximum apply)
Emergency Room Facility (includes ancillary services)	25% Tier 1 deductible and out-of-pocket maximum apply			Section 7.2 and 7.2.4
ER professional/ ancillary services billed separately	25% Tier 1 deductible and out-of-pocket maximum apply			
Urgent Care Office Visits	$45, no deductible	$45, no deductible	50%	Section 7.2.5
Medical Transportation	25%	25%	25%	Section 7.2.3 2 round-trip tickets per year
Preventive Services				
Services as required under the Affordable Care Act, including:	No cost sharing	No cost sharing	50%	Section 7.3 See section for frequency and age limitations
Colonoscopy	No cost sharing	No cost sharing	50%	Section 7.3.1 One per 10 years, age 45+
Contraception	No cost sharing	No cost sharing	50%	Section 7.3.2
Hearing Screening	No cost sharing	No cost sharing	50%	Section 7.3.4 Initial screening within 30 days of birth Additional tests up to age 24 months
Immunizations	No cost sharing	No cost sharing	50%	Section 7.3.3
Mammogram	No cost sharing	No cost sharing	50%	Section 7.3.8 One age 35 - 40 One per year, age 40+

Services	Cost Sharing (Deductible applies unless noted differently)			Section in Handbook & Details
	Tier 1	**Tier 2**	**Tier 3**	
Preventive Health Exams	No cost sharing	No cost sharing	50%	Section 7.3.5 3 exams age 2 - 4 One per year, age 5+
Well-Baby Exams	No cost sharing	No cost sharing	50%	Section 7.3.7 First 24 months of life
Women's Exam & Pap Test	No cost sharing	No cost sharing	50%	Section 7.3.8 One per year
Vision Screening	No cost sharing	No cost sharing	50%	Section 7.3.4 Age 3 - 5
Other Preventive Services including:				
Screening X-ray & Lab	25%	25%	50%	
Prostate Rectal Exam	$30, no deductible	$30, no deductible	50%	Section 7.3.6 One per year, age 40+
Prostate Specific Antigen (PSA) Test	25%	25%	50%	
General Treatment Services				
Acupuncture	$30, no deductible	$30, no deductible	50%	Section 7.4.1 24 visits per year
Anticancer Medication	25%	25%	50%	Section 7.4.2
Applied Behavior Analysis	25%	25%	50%	Section 7.4.3
Biofeedback	25%	25%	50%	Section 7.4.4 10 visit lifetime maximum
Dental Care				Section 7.4.7 Under age 19 Frequency limits apply to some services
Diagnostic & Preventive	No cost sharing	No cost sharing	50%	
Minor restorative services	0%	0%	50%	
Other dental services	40%	40%	50%	
Orthodontia	50%	50%	50%	When medically necessary
Dental Injury	25%	25%	50%	Section 7.4.8

Services	Cost Sharing (Deductible applies unless noted differently)			Section in Handbook & Details
	Tier 1	Tier 2	Tier 3	
Diabetes Services	25%	25%	50%	Section 7.4.9 Supplies covered under Pharmacy benefits
Diagnostic Procedures, including x-ray & lab				Section 7.4.10
Outpatient	25%	25%	50%	
Inpatient	25%	25%	50%	
Durable Medical Equipment, Supplies & Appliances	25%	25%	50%	Section 7.4.11 Limits apply to some DME, supplies, appliances
Home Healthcare	25%	25%	50%	Section 7.4.15 130 visits per year
Hospice Care				Section 7.4.16
Home Care	25%	25%	50%	
Inpatient Care	25%	25%	50%	10 days
Respite Care	25%	25%	50%	240 hours
Hospital Inpatient Care	25%	25%	50%	Section 7.4.17
Hospital Physician Visits	25%	25%	50%	Section 7.4.18
Infusion Therapy (Home or Outpatient)	25%	25%	50%	Section 7.4.19
Kidney Dialysis	25%	25%	50%	Section 7.4.20
Massage Therapy	$30, no deductible	$30, no deductible	50%	Section 7.4.21 24 visits per year
Medical Travel Support				Section 7.4.22
Procedures	No copay or coinsurance	No copay or coinsurance	N/A	Through Surgery Care
Travel and Lodging	No cost sharing	No cost sharing	N/A	
Mental Health Services				Section 7.4.24
Office Visit	$30, no deductible	$30, no deductible	50%	
Intensive Outpatient	$30, no deductible	$30, no deductible	50%	
Other Outpatient Services	25%	25%	50%	
Inpatient	25%	25%	50%	
Partial Hospitalization	25%	25%	50%	
Residential Treatment Programs	25%	25%	50%	

Services	Cost Sharing (Deductible applies unless noted differently)			Section in Handbook & Details
	Tier 1	**Tier 2**	**Tier 3**	
Nutritional Therapy	25%	25%	50%	Section 7.4.26
Office and Home Visits				Section 7.4.27 See also Virtual Care Visits
PCP Visits (including naturopath visits)	$30, no deductible	$30, no deductible	50%	
Specialist Visits	$60, no deductible	$60, no deductible	50%	Section 7.4.27
Psychological or Neuropsychological Testing	$30, no deductible	$30, no deductible	50%	Section 7.4.31 12 hours per year
Outpatient Rehabilitation & Habilitation	$30, no deductible	$30, no deductible	50%	Section 7.4.33 45 sessions per year Limits apply separately to rehabilitation and habilitation services
Inpatient Rehabilitation	25%	25%	50%	Section 7.4.32 30 days per year
Skilled Nursing Facility Care	25%	25%	50%	Section 7.4.34 60 days per year
Spinal Manipulation	$30, no deductible	$30, no deductible	50%	Section 7.4.35 24 visits per year
Substance Use Disorder Services				Section 7.4.36
Detoxification (Detox)	25%	25%	50%	
Office Visit	$30, no deductible	$30, no deductible	50%	
Intensive Outpatient	$30, no deductible	$30, no deductible	50%	
Other Outpatient Services	25%	25%	50%	
Inpatient	25%	25%	50%	
Partial Hospitalization	25%	25%	50%	
Residential Treatment Programs	25%	25%	50%	
Surgery & Invasive Diagnostic Procedures				Section 7.4.37
Outpatient	25%	25%	50%	
Inpatient	25%	25%	50%	
Therapeutic Injections	25%	25%	50%	Section 7.4.38
Therapeutic Radiology	25%	25%	50%	Section 7.4.39

Services	Cost Sharing (Deductible applies unless noted differently)			Section in Handbook & Details
	Tier 1	**Tier2**	**Tier 3**	
Transplants				Section 7.4.40 Includes donor costs
Center of Excellence facilities	25%	25%	N/A	
Other facilities	Not covered	Not covered	Not covered	
Travel, Lodging & Meals	25%	25%	25%	$7,500 per transplant
Virtual Care Visits	$30, no deductible	$30, no deductible	50%	Section 7.4.41
Through CirrusMD	No cost sharing	No cost sharing	N/A	Log on via modahealth.com/ cirrusmd
Maternity Services				
Breastfeeding				Section 7.5.2
Support & Counseling	No cost sharing	No cost sharing	50%	
Supplies			No cost sharing	
Maternity	25%	25%	50%	Section 7.5
Pharmacy				
Prescription Medication	A member who uses an out-of-network pharmacy must pay any amounts charged above the MPA			Section 7.6 Up to 90-day supply for retail and mail order One copay for each 30-day supply No deductible
Retail Pharmacy				
Value Tier	$15		$15	
Select Tier	$15		$15	
Preferred Tier	$30		$30	
Nonpreferred Tier	$60		$60	
Mail Order Pharmacy			Must use Moda-designated mail order pharmacy	
Value Tier	$45			
Select Tier	$45			
Preferred Tier	$90			
Nonpreferred Tier	$180			
Specialty Pharmacy				Up to 30-day supply for most medications
Preferred Specialty	$250	$250	N/A	Must use Moda-designated specialty pharmacy
Nonpreferred Specialty	$250	$250	N/A	

Services	Cost Sharing (Deductible applies unless noted differently)			Section in Handbook & Details
	Tier 1	**Tier 2**	**Tier 3**	
Anticancer Medication	25%	25%	25%	Section 7.4.2 Pharmacy tier deductible applies Mail order and specialty must use Moda-designated pharmacies
Vision Care				
Pediatric Vision Care				Section 7.7.1 Under age 19 No deductible
Exam	No cost sharing		50%	One per year
Lenses & frames or contacts	No cost sharing		50%	One pair per year Frames from the Otis & Piper collection only
Low vision evaluation	No cost sharing		50%	One every year
Low vision services	No cost sharing		50%	4 visits every 5 years for follow up care
Low vision aids	No cost sharing		50%	One low vision aid per year and one pair of high power spectacles per year
Adult Vision Services				Section 7.7.2 Age 19+ No deductible
Well-vision exam	$10		50%	One per year
Lenses & frames	$25		50%	One pair lenses per year and one pair frames every 2 years Tier 1 and Tier 2 up to $130 maximum
Contacts (elective) including contact lens exam	No cost sharing		50%	Once per year, in lieu of frames and lenses Tier 1 and Tier 2 up to $130 maximum

Services	Cost Sharing (Deductible applies unless noted differently)			Section in Handbook & Details
	Tier 1	**Tier 2**	**Tier 3**	
Contacts (medically necessary) including contact lens exam	$25		50%	In lieu of frames and lenses
Low vision testing	No cost sharing		50%	Low vision tests twice every 2 years
Low vision aids	25%		50%	Tier 1 and 2 up to $1,000 maximum every 2 years for all services, testing and aids.
Hearing Coverage				
Hearing exam	20%, no deductible		20%, no deductible	Section 7.8 Ear examination once per 2 years. Other services, including hearing exams, once in a 3-year period. Hearing aids subject to a $3,000 maximum every 3 years
Hearing testing & hardware	20%, no deductible		20%, no deductible	

SECTION 4. PAYMENT & COST SHARING

4.1 DEDUCTIBLES

Every year, members will have to pay some expenses before the Plan starts paying. This is called meeting or satisfying the deductible. The deductible is lower when paid as a Tier 1 benefit. Members must pay all covered expenses until they have spent the deductible amount, unless the Plan specifically says there is no deductible. Then the Plan begins sharing costs with the member.

Once a family member has met their per member deductible, the Plan will begin paying benefits for that member's covered expenses, whether or not the entire family deductible has been met. The deductible amounts, and the amount a member pays after the deductible is met, are show in Section 3. Services accumulated toward the Tier 1 deductible can be used to satisfy the Tier 2 deductible, and services accumulated toward the Tier 2 deductible can be used to satisfy the Tier 1 deductible. Tier 3 amounts accumulate separately. If more than one member of a family is covered, each individual member only has to pay their per member deductible until the total family deductible is reached.

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

4.2 ANNUAL MAXIMUM OUT-OF-POCKET

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

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

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

a. Cost containment penalties
b. Disallowed charges
c. Tier 3 vision benefits for members under age 19
d. Vision benefits for members over age 18
e. Hearing services benefits

4.3 PAYMENT

Moda pays covered expenses based on the maximum plan allowance (MPA), which is a contracted fee for Tier 1 and Tier 2 providers. For Tier 3 providers the MPA is an amount established, reviewed, and updated by a national database (see Section 11). Depending upon the plan provisions, cost sharing may apply.

Except for cost sharing and policy benefit limitations, Tier 1 and Tier 2 providers agree to look solely to Moda, if it is the paying insurer, for compensation of covered services provided to members.

4.4 EXTRA-CONTRACTUAL SERVICES

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

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

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

SECTION 5. NETWORK INFORMATION

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

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

5.1 GENERAL NETWORK INFORMATION

5.1.1 Network and Service Area

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

Networks

For all members:

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

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

5.1.2 Travel Network

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

Travel Network
Aetna PPO

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

5.1.3 Out-of-Network (Tier 3) Care

In Alaska, when members choose healthcare providers that are not in Tier 1 or Tier 2, the benefit from the Plan is lower, at the Tier 3 benefit level. In most cases the member must pay the provider all charges at the time of treatment, and then file a claim to be reimbursed the out-of-network benefit. If the provider's charges are more than the maximum plan allowance, the member may be responsible for paying those excess charges.

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

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

a. Emergency services
b. Coverage through the travel network
c. Coverage through medical travel support (see section 7.4.22)
d. Coverage through out-of-state contracted providers
e. Medically necessary non-emergency services that are prior authorized by Moda

These services are covered at the Tier 1 level. Members are responsible for any amount over the maximum plan allowance.

5.1.4 Care After Normal Office Hours

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

5.2 USING FIND CARE

Find Care is Moda's online directory of Tier 1 and Tier 2 providers. To search for Tier 1 providers, members can log in to their Member Dashboard account at modahealth.com and click on Find Care near the top right of the page. Enter the network name as Pioneer when a network name is required.

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

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

5.2.1 Primary Care Providers

To find a PCP:

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

The search will bring up a list of PCPs.

5.2.2 DME Providers

Find a preferred DME provider for savings on DME:

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

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

SECTION 6. PRIOR AUTHORIZATION

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

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

6.1 PRIOR AUTHORIZATION REQUIREMENTS

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

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

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

6.1.1 Services Requiring Prior Authorization

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

a. Inpatient services and residential programs
b. Outpatient services
c. Rehabilitation including occupational therapy, physical therapy and speech therapy
d. Spinal manipulations or acupuncture services or massage therapy
e. Diagnostic services, including imaging services
f. Infusion therapy
g. Medications
h. Medically necessary non-emergency services outside of the state of Alaska

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

6.1.2 Prior Authorization Limitations

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

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

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

6.1.3 Second Opinion

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

If a member chooses to get a second opinion, it will be paid under the regular medical benefits. The member will have to pay any deductible and other cost sharing that applies.

SECTION 7. BENEFIT DESCRIPTION

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

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

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

7.1 WHEN BENEFITS ARE AVAILABLE

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

a. Is eligible to be covered according to the eligibility provisions of this policy
b. Has applied for coverage and has been accepted
c. Has paid the member's premiums on time for the current month

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

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

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

7.2 URGENT & EMERGENCY CARE

Emergency services will be covered at the Tier 1 benefit level. Information on how members can send a claim to Moda when the provider does not send a claim form on their behalf is found in section 10.1.

7.2.1 Ambulance Transportation

Licensed surface (ground or water) and air ambulance transportation is covered for medically necessary transport to the nearest facility that has the capability to provide the necessary

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

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

7.2.2 Commercial Transportation to Obtain Care

Coverage at the Tier 1 level and limited to one-way air or surface transportation services in the state of Alaska provided by a licensed commercial carrier for a member only, when transportation is for a sudden, life-endangering medical condition that results in a hospital admission. The trip must begin at the location in Alaska where the member became ill or injured and end at the location of the nearest hospital equipped to provide treatment not available in a local facility.

7.2.3 Medical Transportation

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

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

This benefit covers travel for:

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

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

7.2.4 Emergency Room Care

Members are covered for treatment of emergency medical conditions (as defined in Section 11) worldwide. A member who believes they have a medical emergency should call 911 or seek care from the nearest appropriate provider.

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

All claims for emergency services (as defined in Section 11) will be paid at the Tier 1 benefit level. Using a Tier 1 or Tier 2 emergency room does not guarantee that all providers working in the emergency room and/or hospital are also Tier 1 or Tier 2 providers. Tier 3 providers cannot balance bill members except when permitted by law.

Prior authorization is not needed for emergency medical screening exams or treatment to stabilize an emergency medical condition.

If a member's condition requires hospitalization in a Tier 3 facility or a facility outside of Alaska, the treating or attending physician will monitor the condition and determine when the transfer to a Tier 1 facility can be made. The Plan will stop paying Tier 1 benefits for care at the Tier 3 facility beyond the date it is determined the member can be safely transferred.

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

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

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

7.2.5 Urgent Care

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

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. Visits at walk-in clinics and immediate care facilities are covered under the office visit benefit (section 7.4.27). Services will not be paid under the urgent care benefit unless the facility bills as an urgent care facility.

7.3 PREVENTIVE SERVICES

Under the Affordable Care Act (ACA), certain services are covered at no cost to the member when performed by a Tier 1 provider. Tier 2 preventive services are also covered at no cost sharing (see Section 3 for benefits paid at the Tier 3 levels). Moda may use reasonable medical management techniques to determine the most medically appropriate cost effective option that is covered at no cost, as permitted by the ACA. This means that some services listed in section 7.3 below may be subject to member cost sharing:

a. Evidence-based services rated A or B by the United States Preventive Services Taskforce
b. Immunizations recommended by the Advisory Committee on Immunization Practices of the Center for Disease Control and Prevention (ACIP)

c. Preventive care and screenings recommended by the Health Resources and Services Administration (HRSA) for infants, children and adolescents (www.aap.org/en-us/Documents/periodicity_schedule.pdf), and women (www.hrsa.gov/womensguidelines/)

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

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

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

Some commonly used preventive services covered by the Plan are:

7.3.1 Colorectal Cancer Screening

One of the following services, including related charges, for members age 45 and over:

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

If a member has a positive result on a screening recommended by the USPSTF and covered under the preventive benefit, one follow-up colonoscopy will be covered under the preventive benefit.

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

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

7.3.2 Contraception

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

appropriate cost effective option (e.g., generic instead of brand name), will be covered with no cost sharing. Surgery to reverse elective sterilization (vasectomy or tubal ligation) is not covered.

7.3.3 Immunizations

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

7.3.4 Pediatric Screenings

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

a. An initial newborn or infant hearing screening performed by a professional provider within 30 days after the child's birth. If the initial screening determines that the child may have a hearing impairment, additional diagnostic hearing tests up to age 24 months are covered.
b. Routine vision screening to detect amblyopia, strabismus and defects in visual sharpness in children age 3 to 5.
c. Developmental and behavioral health screenings.

7.3.5 Preventive Health Exams

Covered according to the following schedule:

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

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

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

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

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

7.3.7 Well-Baby Exams

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

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

7.3.8 Women's Healthcare

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

Pap tests and breast exams, and mammograms for screening or diagnosis in symptomatic or designated high risk women, are also covered when deemed necessary by a professional provider. These services are covered under the office visit, x-ray or lab test benefit level if not performed within the Plan's age and frequency limits for preventive screening.

7.4 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 . Failure to obtain required prior authorization will result in denial of benefits or a penalty. See section 6.1.1 for more information about prior authorization.

7.4.1 Acupuncture

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

7.4.2 Anticancer Medication

Prescribed anticancer medications, including oral, intravenous (IV) or injected medications, are covered. Most anticancer medications need to be prior authorized and have specific benefit limitations. Specialty anticancer medications require delivery by a Moda-designated specialty pharmacy (see section 7.6.4). For some anticancer medications, members may have to enroll in programs to help make sure the medication is used properly and/or lower the cost of the medication. More information is available on the Member Dashboard or by contacting Customer Service.

7.4.3 Applied Behavior Analysis (ABA)

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

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

Coverage for applied behavior analysis does not include:

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

d. Services provided by the Department of Health and Social Services, other than employee benefit plans offered by the department

7.4.4 Biofeedback

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

7.4.5 Clinical Trials

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

Clinical trials are covered only if the member's treating physician determines that there is no clear superior non-investigational treatment alternative, and available clinical or preclinical data provide a reasonable expectation that the treatment provided in the clinical trial will be at least as effective as any non-investigational alternative.

The following costs are covered:

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

The Plan does not cover:

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

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

7.4.6 Cochlear Implants

Cochlear implants are covered when medically necessary and prior authorized.

7.4.7 Pediatric Dental Care

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

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

   Other diagnostic services not mentioned in this section are not covered such as TMJ films, cone beam CT, viral culture, caries test, stains, immunofluorescence, nutritional or tobacco cessation counseling, oral hygiene instruction, removal of fixed space maintainers and duplication and interpretation of records.

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

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

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

vi. Apexification or recalcification
vii. Pulpal regeneration
viii. Apicoectomy and periradicular surgery
ix. Root amputation
x. Hemisection

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

e. Periodontic
i. Periodontal scaling and root planing once per quadrant in any 2 year period
ii. Periodontal maintenance limited to 4 in any 12 month period combined with prophylaxis
iii. Bone replacement grafts are covered once per quadrant in any 3-year period.
iv. Full mouth debridement limited to once in any 2 year period
v. Gingivectomy or gingivoplasty
vi. Gingival flap procedure
vii. Clinical crown lengthening
viii. Osseous surgery
ix. Pedicle soft tissue graft
x. Free soft tissue graft procedure (including donor site surgery)
xi. Subepithelial connective tissue graft procedures (including donor site surgery)
xii. Collection and application of autologous blood concentrate product once in any 3-year period when dentally necessary

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

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

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

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

v. Prefabricated post and core once per tooth in any 5 year period
vi. Crown repair on a case by case basis

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

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

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

i. Orthodontia

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

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

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

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

Other services not mentioned in this section are not covered such as behavior management, teledentistry (included in the fees for overall patient management and is not covered as a separate benefit), translation or sign language service (included in the fees for overall patient management and is not covered as a separate benefit) and

maxillofacial prosthetics (with the exception of surgical stent mentioned above in section 7.4.7(h)(vi)).

7.4.8 Dental Injury

The Plan covers dental services to treat an accidental injury to natural teeth. Natural teeth are teeth that grew in the mouth. All the following are required to qualify for coverage:

a. The accidental injury must have been caused by a foreign object or was caused by acute trauma (e.g., a broken tooth resulting from biting or chewing food is not an accidental injury)
b. Diagnosis is made within 6 months of the date of injury
c. Treatment must begin within 12 months of the date of injury
d. Treatment is medically necessary and is provided by a physician or dentist while the member is covered by this policy
e. Treatment is limited to that which will restore teeth to a functional state

Implants and implant related services are not covered.

7.4.9 Diabetes Services

Insulin and diabetic supplies including insulin syringes, needles and lancets, test strips, glucometers and continuous glucose monitors are covered under the pharmacy benefit (Section 7.6), when purchased from a pharmacy with a valid prescription and using a preferred manufacturer (see the preferred drug list on the Member Dashboard). Insulin pumps may also be covered under the DME benefit (section 7.4.11) if not obtained from a pharmacy.

Covered medical services for diabetes screening and management include:

a. HbA1c lab test
b. Checking for kidney disease
c. Annual dilated eye exam or retinal imaging, including one by an optometrist or ophthalmologist (no cost sharing Tier 1 and Tier 2)
d. Outpatient self management training or education
e. Medical nutrition therapy when prescribed by a professional provider for the treatment of diabetes

7.4.10 Diagnostic Procedures

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

Diagnostic services including:

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

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

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

7.4.11 Durable Medical Equipment (DME), Supplies & Appliances

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

Some examples of DME, supplies and appliances are:

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

Diabetic supplies, other than insulin pumps and related supplies, are only covered when purchased from a pharmacy with a valid prescription and using a preferred manufacturer (see section 7.6 for coverage under Pharmacy benefit.)

The Plan covers the rental charge for DME. For most DME, the rental charge is covered up to the purchase price. Members can work with their providers to order their prescribed DME. Members may contact Customer Service for help finding a Tier 1 DME provider.

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

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

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

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

Moda 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.

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

7.4.13 Gender Confirming Services
Expenses for gender confirming treatment are covered when the following conditions are met:

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

Covered services may include:

a. Mental health
b. Hormone therapy (including puberty suppression therapy for adolescents)
c. Surgical procedures (see section 7.4.37):
    i. Breast/chest surgery
    ii. Gonadectomy (hysterectomy/oophorectomy or orchiectomy)
    iii. Reconstruction of the genitalia
    iv. Gender confirming facial surgery

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

7.4.15 Home Healthcare

Home healthcare services and supplies are covered when provided by a home healthcare agency for a member who is homebound. Homebound means that the member's condition creates a general inability to leave home. If the member does leave home, the absences must be infrequent, 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 the member's home.

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

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

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

This benefit does not include home healthcare, home care services, and supplies provided as part of a hospice treatment plan. These are covered under sections 7.4.11 and 7.4.16.

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

7.4.16 Hospice Care

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

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

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

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

Hospice Home Care

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

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

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

Respite Care
Respite Care is care for a period of time to provide full-time caregivers relief from residing with and caring for a member in hospice. The Plan covers respite care provided to a member who requires continuous assistance when arranged by the attending professional provider and prior authorized. Benefits are limited to an hourly maximum for services provided in the most appropriate setting. The services and charges of a non-professional provider may be covered for respite care if Moda approves in advance. 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, the following are not covered:

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

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

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

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

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

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

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

7.4.19 Infusion Therapy
The Plan covers the following medically necessary infusion therapy services and supplies.

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

Prior authorization by a professional provider is required for infusion therapy. Members may have the option to choose a preferred medication supplier for some medications. Preferred medication suppliers have agreed to the lower contracted rates and may help members save money. See section 7.6.5 for self-administered infusion therapy. Some services and supplies are not covered if they are billed separately. They are considered included in the cost of other billed charges.

7.4.20 Kidney Dialysis
Covered expenses include:

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

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

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

7.4.22 Medical Travel Support
The Plan covers some surgical procedures at the Tier 1 level when they are provided at a preferred facility, which may include:

Through Surgery Care
- orthopedic
- cardiac
- vascular
- general surgery
- spine
- neurologic
- women's health

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

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

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

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

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

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

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

See section 7.4.19 for more information about infusion therapy. Self-administered medications are not covered under this benefit (see section 7.6.5). See section 7.6 for pharmacy benefits.

7.4.24 Mental Health

The following services by a mental health provider are covered:

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

Intensive outpatient treatment and TMS must be prior authorized.

Intensive outpatient services are more intensive than routine outpatient and less intensive than a partial hospital program. Mental health intensive outpatient is 3 or more hours per week of direct treatment.

A partial hospital program is an appropriately licensed mental 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 state licensed program or facility providing an organized full-day or part-day program of treatment. Residential programs provide overnight 24-hour per day care and include programs to treat mental health conditions. Residential program does not include any program that provides less than 4 hours per day of direct treatment services.

7.4.25 Nonprescription Enteral Formula for Home Use

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

7.4.26 Nutritional Therapy

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

7.4.27 Office or Home Visits

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

7.4.28 Phenylketonuria

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

7.4.29 Podiatry Services

Covered to diagnose and treat a specific current problem. Routine podiatry services are not covered.

7.4.30 Pre-admission Testing

Preadmission testing is covered when ordered by a professional provider.

7.4.31 Psychological or Neuropsychological Testing and Evaluation

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

7.4.32 Inpatient Rehabilitative & Chronic Pain Care

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

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

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

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

7.4.33 Outpatient Rehabilitation and Habilitation & Chronic Pain Care

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

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

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

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

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

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

7.4.34 Skilled Nursing Facility Care

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

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

Exclusions

The following skilled nursing facility charges are not covered:

a. If the member was admitted before they were covered by this policy
b. If the care is mainly for:
    i. Cognitive decline

ii. Dementia, including Alzheimer's disease

c. Routine nursing care
d. Non-medical self-help or training
e. Personal hygiene or custodial care

7.4.35 Spinal & Other Manipulations

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

7.4.36 Substance Use Disorder Services

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

Outpatient treatment programs are state-licensed programs that provide an organized outpatient course of treatment, with services by appointment, for substance-related disorders.

Intensive outpatient services are more intensive than routine outpatient and less intensive than a partial hospital program. 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 substance use disorder 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 state-licensed program or facility providing an organized full-day or part-day program of treatment. Residential programs provide overnight 24-hour per day care and include programs to treat substance use disorder. Residential program does not include any program that provides less than 4 hours per day of direct treatment services.

Room and treatment services for substance use detoxification by a state-licensed treatment program are covered.

7.4.37 Surgery

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

The surgery cost sharing also applies to the following services:

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

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

Certain surgical procedures are covered only when performed as outpatient surgery. Members should ask their professional provider if this applies to a proposed surgery, or contact Customer Service. Outpatient surgery means surgery that does not require an inpatient admission or a stay of 24 hours or more.

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

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

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

Surgery for breast enhancement, making breasts match, and replacing breast implants to accomplish an alteration in breast contour or size is not covered except to treat gender dysphoria (see section 7.4.13) or following a mastectomy.

Reconstructive surgery after a medically necessary mastectomy (Women's Health and Cancer Rights Act of 1998) includes:

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

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

7.4.38 Therapeutic Injections
Administrative services for therapeutic injections, such as allergy shots, are covered when given in a professional provider's office. When comparable results can be obtained safely with self-administered medications at home, the administrative services for therapeutic injections by the provider are not covered. Vitamin and mineral injections are not covered unless they are medically necessary to treat a specific medical condition. More information is in section 7.4.23 and 7.6.5.

7.4.39 Therapeutic Radiology

Covered expenses include:

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

7.4.40 Transplants

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

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

The Plan covers medically necessary transplant procedures that conform to accepted medical practice and are not experimental or investigational. Prior authorization should be obtained as soon as possible after a member has been identified as a possible transplant candidate. To be valid, prior authorization approval must be in writing from Moda.

This section's requirements do not apply to corneal transplants and collecting and/or transfusing blood or blood products (see section 7.4.37).

Benefits for transplants are limited as follows:

a. Transplant procedures must be done at a Center of Excellence. If a Center of Excellence cannot provide the necessary type of transplant, Moda will prior authorize services at another transplant facility
b. Donor costs are covered as follows:
    i. If the recipient or self-donor is enrolled in this policy, donor costs related to a covered transplant are covered
    ii. If the donor is enrolled in this policy and the recipient is not, the Plan will not pay any benefits toward donor costs
    iii. If the donor is not enrolled in the policy, expenses that result from complications and unforeseen effects of the donation are not covered
    iv. Donor costs paid under any other health coverage are not covered by this policy
c. Travel and housing expenses for the recipient and one caregiver, or 2 caregivers if the recipient is a minor, are covered up to a maximum per transplant when the recipient lives more than 50 miles from the Center of Excellence unless the medical condition requires treatment at a closer transplant facility.
d. Professional provider transplant services are paid according to plan benefits for professional providers
e. Immunosuppressive drugs provided during a hospital stay are paid as a medical supply. Outpatient oral and self-injectable prescription medications for transplant related services are paid under the Pharmacy Prescription benefit (section 7.6).
f. The Plan will not pay for chemotherapy with autologous or homogenic/allogenic bone marrow transplant for treatment of any type of cancer not approved for coverage.

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

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

7.4.41 Virtual Care Visits (Telehealth Services)

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

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

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

7.5 MATERNITY CARE

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

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

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

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

Home birth expenses are not covered other than medically necessary supplies and fees billed by a professional provider. Other home birth charges, such as travel and portable hot tubs, are not covered. Supportive services, such as physical, emotional and information support to the mother before, during and after birth and during the postpartum period, are not covered expenses.

7.5.1 Abortion

Elective abortions are covered.

7.5.2 Breastfeeding Support

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

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

7.5.4 Diagnostic Procedures
Diagnostic services, including laboratory tests and ultrasounds, related to maternity care are covered. Some of these procedures may need to be prior authorized. A full list of diagnostic services requiring prior authorization is available on the Moda website or by contacting Customer Service.

7.5.5 Office, Home or Hospital Visits
A visit means the member is actually examined by a professional provider.

7.5.6 Hospital Benefits
Covered hospital maternity care expenses are:

a. **Hospital room**
b. **Facility charges** from a covered facility, including a birthing center
c. **Other hospital services and supplies** when medically necessary for treatment and ordinarily provided by a hospital
d. **Nursery care** includes one in-nursery well-newborn infant preventive health exam. This is covered at no cost sharing when performed by a Tier 1 or Tier 2 provider. Additional visits are covered at the hospital visit benefit level. There is no deductible for routine nursery care. Nursery care is covered under the newborn's own coverage, and is routine while the member is confined in the hospital and receiving maternity benefits.
e. **Take-home prescription drugs** are limited to a 3-day supply at the same benefit level as for hospitalization.

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

7.6 PHARMACY PRESCRIPTION BENEFIT

Prescription medications provided when a member is admitted to the hospital are covered by the medical plan as an inpatient expense; the prescription medications benefit described here does not apply. 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 a member requests, or the treating professional provider prescribes, a brand medication when a generic equivalent is available, the member 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. A prescription price check tool is on the Member Dashboard under the pharmacy tab. This online formulary tool provides coverage information, treatment options and price estimates.

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

Nonpreferred Tier Medications are brand medications, including specialty brand medications that have been reviewed by Moda and do not have significant therapeutic advantage over the preferred alternative. 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 may be purchased without a professional provider's prescription. Moda considers a medication OTC as determined by the FDA.

Preferred Tier Medications are those medications, including specialty preferred medications that have been reviewed by Moda 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. The Moda Prescription Medication List is on the Member Dashboard. It gives information about how commonly prescribed medications are covered. Not every covered medication is on the list. Medications that are new to the market are subject to review and may have additional coverage limitations established by Moda.

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

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

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

Select Tier Medications are the most cost effective options within 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. They can be safely administered by the member or the member's caregiver 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 the Member Dashboard.

7.6.2 Covered Medication Supply

Includes the following:

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

Certain prescription medications and/or quantities of prescription medications may need to be prior authorized (see section 6.1.1). Specialty tier and some other tier medications must be dispensed through a Moda-designated specialty pharmacy.

For assistance coordinating prescription refills, contact Customer Service.

The member can ask for a medication that is not on the formulary by having their professional provider submit an exception request or by contacting Customer Service. Formulary exceptions must be based on medical necessity. The prescribing professional provider's contact information must be submitted, as well as information to support the medical necessity, including all of the following:

a. Formulary medications were tried with an adequate dose and duration of therapy
b. Formulary medications were not tolerated or were not effective
c. Formulary medications would reasonably be expected to cause harm or not produce equivalent results as the requested medication
d. The requested medication treatment is not experimental or investigational

Moda will contact the prescribing professional provider to find out how the medication is being used in the member's treatment plan. Standard exception requests are decided within 72 hours. Urgent requests are decided within 24 hours. 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 Mail Order Pharmacy

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

7.6.4 Specialty Services & Pharmacy

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

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

Some specialty prescriptions may be limited to less than 30 days. Some medications may be eligible for a 90-day supply. For some specialty medications, members may have to enroll in a program to ensure proper medication use and/or lower the cost of the medication. More information is available on the Member Dashboard or by contacting Customer Service.

7.6.5 Self-Administered Medication

All self-administered medications follow all of the prescription medication requirements of section 7.6. Self-administered specialty medications are subject to the same requirements as other specialty medications (section 7.6.4).

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

7.6.6 Step Therapy

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

7.6.7 Limitations

a. New FDA approved medications are subject to review and may have additional coverage requirements or limits set by the Plan. A member or prescriber can request a medical necessity evaluation if a newly approved medication is initially denied during the review period.

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

7.6.8 Exclusions

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

a. **Devices.** Including but not limited to therapeutic devices and appliances. Information for contraceptive devices is in section 7.3.2 and for other devices in section 7.6.2
b. **Foreign Medication Claims.** Medications purchased from non-U.S. mail order or online pharmacies or U.S. mail or online pharmacies acting as agents of non-U.S. pharmacies.
c. **Hair Growth Medications.**
d. **Immunization Agents for Travel.** Except as required under the Affordable Care Act.
e. **Institutional Medications.** To be taken by or administered to a member while they are a patient in a hospital, rest home, skilled nursing facility, extended care facility, nursing home, or similar institution.
f. **Medication Administration.** A charge to administer or inject a medication, except for immunizations at retail pharmacies.
g. **Medications Covered Under Another Benefit.** Such as medications covered under hospice, home health, medical, etc.
h. **Medications Not Approved by FDA.** Products not recognized or designated as FDA approved medications. This includes medications that are found to be less than effective by the FDA's Drug Efficacy Study Implementation (DESI) classifications.
i. **Non-Covered Condition.** A medication prescribed for reasons other than to treat a covered medical condition.
j. **Nutritional Supplements and Medical Foods.**
k. **Off-label Use.** Medications prescribed for or used for non-FDA approved indications, unless confirmed by other research studies, reference, compendium, or the federal government.

l. **Over the Counter (OTC) Medications** and certain prescription medications that have an OTC option (see the preferred drug list on the Member Dashboard), except those treating tobacco dependence.
m. **Pharmacies excluded from the network.** Medications from pharmacies that have been excluded from the network for non-compliance with fraud, waste and abuse laws.
n. **Repackaged Medications.**
o. **Replacement Medications and/or Supplies.**
p. **Vitamins and Minerals.** Except as required by law.
q. **Weight Loss Medications.**

7.7 VISION CARE BENEFIT

7.7.1 Pediatric Vision Services

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

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

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

For members who are eligible for vision plan benefits, VSP will provide benefit authorization directly to the Tier 1 or Tier 2 doctor. When contacting a Tier 1 or Tier 2 doctor directly, members must identify themselves as VSP members so the doctor will obtain benefit authorization from VSP. Should members receive services from a Tier 1 or Tier 2 doctor without such benefit authorization or obtain services from a provider who is not a Tier 1 or Tier 2 doctor, they are responsible for payment in full to the provider and will need to submit a request for reimbursement by completing the member reimbursement claim form, which is available by visiting www.vsp.com or calling 800-877-7195. Payment in these instances is limited to those for a Tier 3 provider.

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

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

7.7.2 Adult Vision Care Services

The Plan pays for vision examinations and corrective lenses and frames for members age 19 and older. Members can visit www.vsp.com or call 800-877-7195 to choose a Tier 1 or Tier 2 vision care provider and arrange for vision services. Some vision services may need to be prior authorized.

For members who are eligible for vision plan benefits, VSP will provide benefit authorization directly to the Tier 1 or Tier 2 doctor. When contacting a Tier 1 or Tier 2 doctor directly, members must identify themselves as VSP members so the doctor will obtain benefit authorization from VSP. Should members receive services from a Tier 1 or Tier 2 doctor without such benefit authorization or obtain services from a provider who is not a Tier 1 or Tier 2 doctor, they are responsible for payment in full to the provider and will need to submit a request for reimbursement by completing the member reimbursement claim form, which is available by visiting www.vsp.com or calling 800-877-7195. Payment in these instances is limited to those for a Tier 3 provider.

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

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

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

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

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

7.8 HEARING SERVICES BENEFIT

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

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

To get the highest benefit level for a hearing aid, members can call 866-202-2178 to choose a Tier 1 audiologist and arrange for a hearing exam. The audiologist will assist members with choices of hearing aids through a Tier 1 hearing instrument provider. The hearing services vendor has a selection of hearing aids available to Plan members.

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

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

SECTION 8. GENERAL EXCLUSIONS

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

Animal Therapy

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

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

Charges Over the Maximum Plan Allowance

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

Cosmetic Procedures
Any procedure or medication requested for the purpose of improving or changing appearance without restoring impaired bodily 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 section 7.4.13 and mastectomy, section 7.4.37)

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

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

Dental Examinations and Treatment; Orthodontia
Except services described in sections 7.4.7 and 7.4.8

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

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

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

Faith Healing

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

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

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

Homeopathic Treatment and Supplies

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

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

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

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

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

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

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

Nutritional Therapy
Except as described in section 7.4.26

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

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

The Plan covers services and supplies that are necessary 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 7.4.11

Orthognathic Surgery
Including associated services and supplies

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

Personality Disorders

Physical Exercise Programs
Programs, videos and exercise equipment

Private Nursing Services

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

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

Routine Foot Care
Including the following services unless otherwise required by the member's medical condition (such as diabetes):

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

Self-Administered Medications
Including oral and self injectable, when provided directly by a physician's office, facility or clinic instead of through the pharmacy prescription medication or anticancer benefits (sections 7.6.5 and 7.4.2)

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

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

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

Services Not Provided
If a member has not actually received the service or supply, no benefits will be paid. This includes missed appointments.

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

a. A member has not been charged or the charge has been reduced or discounted, or a member would not normally be charged if they do not have insurance
b. Another third party has paid or is obligated to pay, or would have paid if a member had applied for the program. This may include a government program (except Medicaid) or a hospital or program operated by a government agency or authority.

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

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

Services Provided by Volunteer Workers

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

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

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

Telehealth
Including Telemedicine, telephone visits or consultations and telephone psychotherapy, except for electronic visits covered in section 7.4.12 and virtual care visits (telehealth) covered in section 7.4.41

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

Third Party Liability Claims
Services and supplies to treat a medical condition that a third party is or may be responsible for, to the extent of any recovery received from or on behalf of the third party (see section 10.4.3)

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

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

Treatment Before Coverage Begins

Treatment 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 mental health or substance use disorder condition, or treatment of normal transitional response to stress

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

a. Not medically necessary for the treatment or diagnosis of a condition otherwise covered by the Plan or are prescribed for purposes other than treating disease
b. Inappropriate or inconsistent with the symptoms or diagnosis of a member's condition
c. Not established as the standard treatment by the medical community in the service area in which they are received

d. Primarily for the convenience of a member or provider
e. Not the least costly of the alternative supplies or levels of service that can be safely provided to a member

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

Vision Care
Except as otherwise covered under the Plan. This includes any charges for orthoptics or vision training and any associated supplemental testing, vitamin therapy, low vision therapy, eye exercises or fundus photography. See section 7.4.9 for coverage of annual dilated eye exam to manage diabetes.

Vision Surgery
Any procedure to cure or reduce near-sightedness, far-sightedness, or astigmatism, including reversal 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 arising out of or in the course of employment or self-employment for wages or profit, whether or not the expense is paid under any workers' compensation provision. This exclusion does not apply to owners, partners or executive officers if they are exempt from workers' compensation laws and their employer does not provide workers' compensation coverage to them.

SECTION 9. ELIGIBILITY & ENROLLMENT

If this is a child only policy, coverage is only available to age 26. Dependent children, spouses, and domestic partners of the subscriber are not covered. Disregard any reference to spouses, domestic partners or children. 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 the first of the following month.

A person cannot be covered by more than one Moda individual medical policy at any time.

Eligibility and enrollment, are administered by the Health Insurance Marketplace. Contact the Health Insurance Marketplace for information. A subscriber may add newly acquired or newly eligible dependents to the coverage by submitting an application along with any supporting documentation within 60 days of their eligibility. A new dependent may cause a premium increase. The required premium or any applicable premium credit must be received and processed for coverage to become effective.

The subscriber must notify the Health Insurance Marketplace if family members are added or dropped from coverage, even if it does not affect premiums. Moda must be notified whenever there is a change of address.

To remain eligible for coverage, a person must satisfy the residency requirements of the Health Insurance Marketplace. This includes living in the service area, and intending to live in the service area permanently or indefinitely. Coverage is not available to a person who lives in the service area for the primary purpose of obtaining health coverage or other temporary purpose such as getting treatment.

A subscriber's child who has sustained a disability making them physically or mentally incapable of self-support at even a sedentary level may be eligible for coverage even though they are over 26 years old. To be eligible, the child must be unmarried and principally dependent on the subscriber or the subscriber's parent for support and have had continuous medical coverage. The incapacity must have started, and the information below must be received, before the child's 26th birthday. Social Security Disability status does not guarantee coverage under this provision. Moda will determine eligibility based on commonly accepted guidelines. To avoid a break in coverage, it is recommended that the following information be submitted to Moda at least 45 days before the child's 26th birthday:

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

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

9.1 ELIGIBILITY AUDIT

Moda reserves the right to conduct audits to verify a member's eligibility, and may request documentation including but not limited to medical and certain financial records and birth certificates, adoption paperwork, marriage certificates, domestic partner registration, proof of residency and any other evidence necessary to document eligibility on the policy.

9.2 PREMIUMS

The current premium amount is shown on the premium notice. Members may contact the Health Insurance Marketplace regarding premium tax credits.

Premium payments are due monthly for continued coverage. Payments can be made by check, cashier's check, money order or prepaid debit card with a billing statement, or by electronic fund transfer (EFT). If a subscriber no longer wishes to pay by EFT, Moda must be notified in writing 15 days before the next deduction date. For other changes in billing option, Moda must receive 30 days prior written notice from the subscriber. Electronic billing (eBill) is also available, allowing subscribers to pay the monthly premium on the Member Dashboard using their bank account.

Premium payments by third parties are not accepted, except when required by law.

9.2.1 When Payments are Due

All premium payments are due on the first of the month. If payment is not received within the grace period (section 9.2.2), this policy will end after an advance delinquency and termination notice.

This policy continues for each month a subscriber makes a timely premium payment.

9.2.2 Grace Period

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

9.2.3 Reinstatement

If any renewal premiums are not paid within the time allowed for payment, a subsequent acceptance of premiums by Moda or by any agent authorized by Moda to accept such premiums shall be subject to an application for reinstatement and a conditional receipt will be issued for the premiums received. The policy will be reinstated upon approval of such application by Moda or, lacking such approval, upon the 45th day following the date of the conditional receipt unless Moda has previously notified the subscriber in writing of its disapproval of the application. The reinstatement policy only covers claims resulting from an accidental injury sustained after the date of reinstatement and claims due to sickness beginning more than 10 days after the reinstatement date. In all other respects the subscriber and Moda 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.

9.2.4 Changes in Amount of Premiums

Premiums can change without notice when the family composition or eligibility status changes. The new premium amount will be effective the first day of the month following the event. When a member moves into the next age bracket of the rate table, premiums will change on the renewal date. 45 days written notice will be provided before a change in the premiums affecting all policyholders takes effect. When the new premium is paid, the payment will confirm the subscriber's acceptance of the change.

9.2.5 Segregation of Premium for Abortion Services

The first full dollar of any member-paid monthly premium is allocated to abortion services for which public funding is prohibited. Federal regulations require the premium for these services be at least $1.00 per member per month, regardless of age or gender.

9.3 WHEN COVERAGE ENDS

The circumstances in which a member's coverage will end are described below. Coverage will end on the last day of the month through which premiums are paid unless otherwise required by law. When the subscriber's coverage ends, coverage for all enrolled dependents also ends.

a. Subscriber is no longer eligible for coverage through the Health Insurance Marketplace
b. The subscriber or dependent moves outside the Plan's service area
c. Loss of dependent eligibility
d. Non-payment of premium
e. Rescission as described in section 9.4
f. Termination of the health benefit plan option
g. Moda's decertification to offer plans through the Health Insurance Marketplace
h. Subscriber ends their coverage after the required advanced notice or changes health benefit plan during an open enrollment or special enrollment period

9.4 RESCISSION

A member's coverage may be rescinded back to the effective date, or claims denied at any time, for fraud or intentional material misrepresentation. This may include but is not limited to: enrolling ineligible persons in the policy, falsifying or withholding documentation or information that is the basis for eligibility, and falsification or alteration of claims. Moda reserves the right to retain premiums paid as liquidated damages, and the member shall be responsible for the full balance of any benefits paid. A member will be notified of a rescission 30 days prior to cancellation of coverage.

SECTION 10. CLAIMS ADMINISTRATION & PAYMENT

10.1 SUBMISSION & PAYMENT OF CLAIMS

10.1.1 Notice of Claim

A claim is not payable until the service or supply has actually been received. Written notice of claim must be given to Moda as soon as reasonably possible after the occurrence or commencement of a loss covered by the policy. In no event, except absence of legal capacity, is a claim valid if submitted later than 12 months from the date the expense was incurred. Notice may be given by or on behalf of a member to Moda at P.O. Box 40384, Portland, Oregon 97240.

Moda does not require members to use a specific claim form. Information on how members can submit notice of a claim when the provider does not submit a claim form on their behalf is found in sections 10.1.2 to 10.1.7.

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

10.1.2 Hospital & Professional Provider Claims

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

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

When a member is billed by the hospital or professional provider directly, they should send a copy of the bill to Moda and 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

Some claims will require additional information:
Accidental injury: include the date, time, place, and description of the accident.

For care received outside the United States see section 10.1.7.

10.1.3 Ambulance & Commercial Transportation Claims

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

10.1.4 Prescription Medication Claims

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

A member who fills a prescription at an out-of-network pharmacy that does not access Moda's claims payment system will need to submit a request for reimbursement by completing the prescription medication claim form, which is available on the Member Dashboard or by contacting Customer Service.

10.1.5 Vision Services Claims

A member who has vision services provided by a Tier 3 provider or a Tier 1 or Tier 2 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 call 800-877-7195.

10.1.6 Out-of-Country or Foreign Claims

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

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

10.1.7 Payment of Claims

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

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

10.1.8 Explanation of Benefits (EOB)

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

If a member does not receive an EOB or an email indicating that an EOB is available within a few weeks of the date of service, this may indicate that Moda has not received the claim. To be

eligible for reimbursement, claims must be received within the claim submission period explained in section 10.1.

10.1.9 Claim Inquiries

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

10.1.10 Time Frames for Processing Claims

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

If additional information is needed to process the claim for reasons beyond Moda's control, a notice will be sent to the member explaining what information is needed within 30 days after Moda receives the claim. The party responsible for providing the additional information will have 45 days to submit it. Moda will then complete its processing and send an EOB to the member no later than 15 days after receiving the information or 30 days of original receipt of the claim.

If a claim is not processed timely, interest of 15% annually will accrue until processing of the claim is complete. Submission of information necessary to process a claim is also subject to the Plan's claim submission period explained in section 10.1.1.

10.1.11 Time Frames for Processing Prior Authorizations and Utilization Review

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

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

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

10.2 COMPLAINTS, APPEALS & EXTERNAL REVIEW

Before filing an appeal that does not concern initial eligibility, it may be possible to resolve a dispute with a phone call to Customer Service.

10.2.1 Time Limit for Submitting Appeals

Members have **180 days** from the date they receive notice of an adverse benefit determination to submit a written appeal. If an appeal is not submitted within this timeframe, the right to the appeal process may be lost. Members may file a written request for extension to the timeframes outlined in this section. The request must include at least one justification, with a fair and reasonable basis for allowing the extension.

The timelines addressed in section 10.2 do not apply when the member does not reasonably cooperate, or circumstances beyond the control of either party (Moda or the member) makes it impossible to comply with the requirement. Whoever is unable to comply must give notice of the specific reason to the other party as soon as possible when the issue arises).

10.2.2 Appeals

Appeals regarding eligibility, including premium tax credit and allocations or American Indian and Alaskan Native eligibility status should be sent to the Health Insurance Marketplace.

Appeals of other adverse benefit determinations are administered by Moda. An appeal must be submitted in writing. For claims involving urgent care, the appeal may be made by phone. If necessary, Customer Service can help with filing an appeal. The member may review the claim file and present evidence and testimony as part of the appeal process, and may appoint a representative to act on their behalf. Moda will acknowledge receipt of a written appeal and provide notice of the appeal provisions within 3 business days and conduct an investigation by persons who were not involved in the initial determination.

An appeal related to an urgent care claim can have a faster review upon request. Reviews of appeals that meet the criteria to be expedited will be finished within 72 hours after Moda has received those appeals, unless the member fails to provide enough information for Moda to make a decision. In this case, Moda will notify the member within 24 hours of receiving the appeal of the specific information necessary to make a decision. The member must provide the specified information as soon as possible. The investigation of an urgent care claim will be completed no later than 48 hours following the earlier of (a) when Moda receives the specified information, or (b) the end of the period provided to submit the specified additional information.

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

Moda will provide for a written decision by a Moda employee or agent who holds the same or similar specialty as would typically manage the case being reviewed. If new or additional evidence or rationale is used by Moda in connection with the claim, it will be provided to the member, in advance and free of charge, before any final internal adverse benefit determination. The member may respond to this information before Moda's determination is finalized. Moda will send a written notice of the decision to the member, including the reason for the decision, and if applicable, information on the right to external review.

10.2.3 Appeals on Ongoing Care

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

10.2.4 External Review

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

a. The member must sign a HIPAA release waiver allowing the IRO to see their medical records.

b. The dispute must relate to:
    i. An adverse benefit determination or final internal adverse benefit determination that involves medical judgment or rescission but does not include disputes about eligibility to participate in the Plan, except for those related to rescissions
    ii. Cases in which Moda does not meet the internal timeline for review or the state or federal requirements for providing related information and notices
c. The request for external review must be made in writing to the director of the Alaska Division of Insurance no more than 180 days after receipt of the adverse benefit determination or the final internal adverse benefit determination. For expedited review, the request may be made by phone. A member may submit additional information to the IRO within 5 business days, or 24 hours for an expedited review. Members may file a written request for extension to the 180-day limit. The request must include at least one justification, with a fair and reasonable basis for allowing the extension.
d. The member must have finished the appeal process described in section 10.2.3. However, Moda may waive this requirement and have an appeal referred directly to external review with the member's consent.
e. The member shall provide complete and accurate information to the IRO in a timely manner.

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

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

10.2.5 Complaints

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

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

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

10.2.6 Additional Member Rights

Members have the right to file a complaint or ask for help from the Alaska Division of Insurance.

Phone: 907-269-7900 or toll free 800-467-8725
Fax: 907-269-7910
Mail: Division of Insurance
Consumer Services Section
550 West 7th Avenue, Suite 1560
Anchorage, AK 99501-3567

Email: insurance@alaska.gov
Internet: www.commerce.alaska.gov/web/ins/Consumers/Complaint.aspx

10.2.7 Definitions

For purposes of section 10.2, the following definitions apply:

Adverse Benefit Determination is a written notice from Moda in the form of a letter or an Explanation of Benefits (EOB), of any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including one based on a determination of a person's eligibility to participate in the Plan and one resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not necessary and customary by the standards of generally accepted practice for the prevention or treatment of disease or accidental injury.

A **Final Internal Adverse Benefit Determination** is an adverse benefit determination that has been upheld by Moda at the completion of the internal appeal process or with respect to which the internal appeal process has been exhausted.

Appeal is a written request by a member or their representative for Moda or the Health Insurance Marketplace to review an adverse benefit determination.

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

Claim Involving Urgent Care is any claim for medical care or treatment in which the application of the regular time period to review a denial of a pre-service claim could

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

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

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

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

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

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

10.3 CONTINUITY OF CARE

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

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

2. Regarding continuity of care with a facility

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

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

10.4 BENEFITS AVAILABLE FROM OTHER SOURCES

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

10.4.1 Coordination of Benefits (COB)

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

If the member is covered by another plan or plans, the benefits under this Plan and the other plan(s) will be coordinated. This means one plan pays its full benefits first, then any other plans pay. The order of benefit determination rules decide the order in which each plan will pay a claim for benefits. (For coordination with Medicare, see section 10.4.2.)

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

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

a. **Non-dependent/Dependent.** If a plan covers the member as other than a dependent (e.g., an employee, member of an organization, primary insured, or retiree), then that plan will determine its benefits before a plan that covers the member as a dependent. However, if the member is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the member as a dependent and primary to the plan covering the member as other than a dependent (e.g. a retired employee), then the order of benefits between the 2 plans is reversed.
b. **Dependent Child/Parents Married or Living Together.** If the member is a dependent child whose parents are married or living together whether or not they have ever been married, the plan of the parent whose birthday falls earlier in the calendar year is the primary plan. If both parents' birthdays are on the same day, the plan that has covered the parent the longest is the primary plan. (This is called the 'birthday rule.') If another plan does not include the birthday rule, but instead has a rule based on the gender of the parent, then that plan is the primary plan.
c. **Dependent Child/Parents Separated or Divorced or Not Living Together.** If the member is a dependent child of divorced or separated parents, or parents not living together whether or not they have 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.

10.4.1.2 How COB Works

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

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

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

10.4.1.3 COB and Plan Limits

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

10.4.1.4 Pharmacy COB

Claims subject to the COB provision of the policy may be submitted electronically by pharmacies or through the direct member reimbursement paper claim process. The preferred method is for the pharmacy to electronically transmit the primary plan's remaining balance to Moda for processing. If approved, the secondary claim will be automatically processed according to plan benefits. Members who are unable to have their secondary claims processed electronically may submit a claim reimbursement request directly to Moda (see section 10.1.4).

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

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

Approved by Primary:

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

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

10.4.1.5 Definitions

For purposes of Section 10, the following definitions apply:

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

Plan includes:

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

Plan does not include:

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

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

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

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

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

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

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

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

10.4.2 Coordination with Medicare

The Plan coordinates benefits with Medicare as required under federal government rules and regulations. To the extent permitted by law, the Plan will not pay for any part of a covered expense that is actually paid under Medicare or would have been paid under Medicare if the member had enrolled in Medicare when eligible. The Plan will estimate what Medicare would have paid and reduce its benefits based on the estimate. In addition, the Plan does not pay for any part of expenses incurred from providers who have opted out of Medicare participation. A member who chose not to enroll in Medicare when first eligible or canceled Medicare after initial enrollment may have to pay any expenses not paid by the Plan.

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

10.4.3 Third Party Liability

A member may have a legal right to recover benefit or healthcare costs from a third party as a result of a medical condition for which such costs were paid by Moda. The policy does not cover benefits for which a third party may be legally liable. Because recovery from a third party may be difficult and take a long time, as a service to the member Moda will pay a member's expenses based on the understanding and agreement that Moda is entitled to be reimbursed in full from any recovery the member may receive for any benefits paid that are or may be recoverable from a third party or other source no matter how the recovery is characterized.

The member agrees that Moda has the rights described in section 10.4.3. Moda may seek recovery under one or more of the procedures outlined in this section. The member agrees to do

whatever is necessary to fully secure and protect, and to do nothing to prejudice, Moda's right of recovery or subrogation as discussed in this section.

10.4.3.1 Definitions

For purposes of section 10.4.3, the following definitions apply:

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

Recovery Funds means any amount recovered from a third party.

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

Third Party Claim means any claim, lawsuit, settlement, award, verdict, judgment, arbitration decision or other action against a third party (or any right to such an action) by or on behalf of a member, regardless of how the claims, damages or recovery funds are characterized. (For example, a member who has received payment of medical expenses from Moda may file a third party claim, but only seek the recovery of non-economic damages. In that case, Moda is still entitled to recover benefits as described in section 10.4.3.)

10.4.3.2 Subrogation

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

10.4.3.3 Right of Recovery

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

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

b. Moda is entitled to receive the amount of benefits it has paid for a medical condition out of any settlement or judgment that results from exercising the right of recovery against the third party. This is so whether or not the third party admits liability or claims that the member is also at fault. In addition, Moda is entitled to receive the amount of benefits it has paid whether the healthcare expenses are itemized or expressly excluded in the third party recovery.

c. If Moda requires the member and their attorney to protect its recovery rights under this section, then the member may subtract from the money to be paid back to Moda a proportionate share of reasonable attorney fees as an expense for collecting from the other party.

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

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

10.4.3.4 Additional Provisions

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

a. The member shall cooperate with Moda to protect its recovery rights, including by:
   i. Signing and delivering any documents Moda reasonably requires to protect its rights, including a Third Party Reimbursement Questionnaire and Agreement. If the member has retained an attorney, then the attorney must also sign the agreement. Moda will not be required to pay benefits until the agreement is properly signed and returned
   ii. Providing any information to Moda relevant to the application of the provisions of section 10.4.3, including all information available to the member, or any representative or attorney representing the member, relating to the potential third party claim. This may include medical information, settlement correspondence, copies of pleadings or demands, and settlement agreements, releases or judgments
   iii. Notifying Moda of the potential third party claim for which the Plan may issue benefits. The member has this responsibility even if the first request for payment of benefits is a bill or invoice submitted to Moda by the member's provider
   iv. Taking such actions as Moda may reasonably request to assist it in enforcing its third party recovery rights

b. The member and their representatives are obligated to notify Moda in advance of any claim (written or oral) and/or any lawsuit made against a third party seeking recovery of any damages from the third party, whether or not the member is seeking recovery of benefits paid by Moda from the third party.

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

d. The member agrees that Moda may notify any third party, or third party's representatives or insurers, of its recovery rights described in section 10.4.3.

e. Even without the member's written authorization, Moda may release to, or obtain from, any other insurer, organization or person, any information it needs to carry out the provisions of section 10.4.3.

f. Section 10.4.3 applies to any member for whom advance payment of benefits is made by the Plan whether or not the event giving rise to the member's injuries occurred before the member became covered by Moda.

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

h. If the member or the member's representatives fail to do any of the above mentioned acts, then Moda has the right to not advance payment or to suspend payment of any benefits, or to recover any benefits it has advanced, for any medical condition resulting from the event giving rise to, or the allegations in, the third party claim. Moda may notify medical providers seeking authorization of payment of benefits that all payments have been suspended and may not be paid.

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

SECTION 11. DEFINITIONS

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

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

Authorization see Prior Authorization.

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

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

Coinsurance is the percentages of covered expenses to be paid by a member. If the coinsurance is 20%, the member pays 20% of the covered charge and the Plan pays the other 80%.

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

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

Cost Sharing is the share of costs a member must pay when receiving a covered service. It includes deductible, copayments or coinsurance. Cost sharing does not include premiums, balance billing amounts for Tier 3 or out-of-state providers or the cost of non-covered services.

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

Creditable Coverage means a member's prior healthcare coverage, including coverage remaining in force at the time a member obtains new coverage, as defined in 26 US Code §9801(c)(1).

Custodial Care means care that helps a member conduct 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 a member must pay before the Plan starts paying. If the member gets Tier 1, Tier 2 and Tier 3 services, 3 separate deductibles may apply.

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

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

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

The domestic partner and subscriber

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

Effective Date means the 1st of the following month if an application is received unless another date is selected. For new dependents, effective date means the date of birth for a newborn child, the date of the adoption decree for an adopted child, and the date of placement for a child placed for adoption. For new spouses and domestic partners, and persons who qualify due to loss of minimum essential coverage, it means the 1st day of the month following 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 means the medical history, examination, related tests and medical determinations required to confirm the nature and extent of an emergency medical condition.

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

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

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

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

a. Involve a treatment for which scientific or medical assessment has not been completed, or the effectiveness of the treatment has not been generally established. This includes a treatment program that may be proven for some uses, but scientific literature does not support the use as requested or prescribed. An example is a medication that is proven as a treatment when used alone, but scientific literature does not support using it in combination with other therapies.
b. Are available in the United States only as part of a clinical trial or research program for the illness or condition being treated
c. Are not provided by an accredited institution or provider within the United States or are provided by one that has not demonstrated medical proficiency in the provision of the service or supplies
d. Are not recognized by the medical community in the service area in which they are received
e. Involve a treatment for which the approval of one or more government agencies is required, but has not been obtained at the time the services and supplies are provided or are to be provided

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

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

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

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

Implant is a material inserted or grafted into tissue.

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

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

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

MPA for Tier 3 providers in Alaska is the lesser of billed charges or the 80th percentile of fees commonly charged for a given procedure in a given area, based on a national database.

MPA for out-of-state providers is the lesser of supplemental provider fee arrangements Moda may have in place and the 80th percentile of fees commonly charged for a given procedure in a given area, based on a national database.

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

MPA for Tier 3 services under the vision benefit is the lesser of the provider's billed charges or the 80th percentile of fees commonly charged for a given procedure in a given area.

MPA for Tier 3 and out-of-state facilities such as hospitals, ambulatory surgical centers, home health providers, skilled nursing facilities and residential treatment programs is the lesser of supplemental facility or provider fee arrangements Moda may have in place, the 80th percentile of fees commonly charged for a given procedure in a given area based on a national database, or the billed charge.

MPA for emergency services received out-of-network, out-of-network air ambulance, or out-of-network services in an in-network facility where the member is not able to choose the provider is the greatest of the median Tier 1 and Tier 2 rates, the maximum amount as calculated according to this definition for Tier 3 providers and the Medicare allowable amount.

MPA for Tier 3 and out of state end-stage renal disease (ESRD) facilities is 125% of the Medicare allowable amount for members eligible for Medicare.

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

When using a Tier 3 or out-of-state provider, any amount above the MPA may be the member's responsibility (this is the balance billing amount) unless balance billing is prohibited by federal law.

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

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

a. It agrees with standards that are based on credible scientific evidence published in peer reviewed medical literature in relation to effectiveness for services, medications and interventions for medical condition and patient indications
b. It is consistent with the symptoms or diagnosis of a member's condition and appropriate considering the potential benefit and harm to the patient

c. The service, medication, supply or intervention is known to be effective in improving health outcomes
d. The service, medication, supply or intervention is cost-effective compared to the alternative intervention, including no intervention

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

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

Medically necessary care does not include custodial care.

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

Member is a person whose application for individual healthcare insurance coverage has been accepted and who is enrolled for coverage under the terms of this policy. A member may be the subscriber or a dependent of a subscriber.

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

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

Moda refers to Moda Assurance Company.

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

Non-Contracted Provider is a provider not contracted with an insurance company to provide healthcare services to members.

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

Out-of-Pocket Maximum is the maximum amount a member pays out-of-pocket every year, including the deductible, coinsurance and copays. If a member obtains Tier 1, Tier 2 and Tier 3 services, 3 separate out-of-pocket maximums apply. If a member reaches the out-of-pocket maximum in a calendar year, the Plan will pay 100% of eligible expenses for the rest of the year.

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

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

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

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

Prior Authorization or **Prior Authorized** refers to getting approval from Moda before the date of service. A complete list of services and medications that require prior authorization is available on the Member Dashboard or by contacting Customer Service. A service, supply or medication that is not prior authorized when required will result in denial of benefits or a penalty (see Section 6).

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

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

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

Subscriber is the person in whose name the policy is issued following acceptance by the Health Insurance Marketplace of that person's application.

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

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

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

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

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

SECTION 12. GENERAL PROVISIONS & LEGAL NOTICES

12.1 MEMBER DISCLOSURES

Members have the right to:

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

Members have the responsibility to:

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

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

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

12.2 GENERAL & MISCELLANEOUS

Entire Policy
This policy plus the application and any declaration pages, addendums, endorsements or amendments are the entire contract between the parties. No promises, terms, conditions or obligations exist other than those contained in the contract. No change in this policy shall be valid until approved by an executive officer of Moda and unless the approval is endorsed or attached to the policy. No agent has authority to change this policy or to waive any of its provisions. This policy plus any application, declaration page, endorsements or amendments shall supersede all other communications, representations or agreements, either verbal or written between the parties. If any term, provision, agreement or condition is held by a court of competent jurisdiction to be invalid or unenforceable, the remainder of the provisions shall remain in full force and effect and shall in no way be affected, impaired or invalidated.

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

Confidentiality of Member Information
Keeping a member's protected health information (PHI) confidential is very important to Moda. Protected health information includes enrollment, claims, and medical and dental information. Moda uses this information to pay claims and authorize services. It is also used for referrals, case management and quality management programs. Moda does not sell this information. The Notice of Privacy Practices has more detail about how Moda uses the members' PHI. Members can follow the Privacy Center link on the Moda website for a copy of the notice or call 855-425-4192.

Right to Collect & Release Needed Information
In order to receive benefits, the member must give or authorize a provider to give Moda any information needed to pay benefits. Moda may release to or collect from any person or organization any needed information about the member.

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

Correction of Payments or Recovery of Benefits Paid by Mistake
If Moda mistakenly makes a payment for a member to which they are not entitled, or pays a person who is not eligible for payments at all, Moda has the right to initiate recovery of the payment from the person paid or anyone else who benefited from it, including a provider, within 365 days of the date the original payment was made. Moda's right to recovery includes the right to deduct the amount paid from future benefits it would provide for a member even if the mistaken payment was not made on that member's behalf. Moda will give a provider or member 30 calendar days written notice prior to recovering a payment. The provider or member has the right to challenge the recovery.

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 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's rights to enforce the provisions of the policy.

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

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

Where any Legal Action must be Filed
Any legal action arising out of this policy must be filed in either state or federal court in the state of Alaska.

Time Limit for Filing a Lawsuit
Any legal action arising out of, or related to, this policy and filed against Moda by a member or any third party must be filed in court at least 60 days, but no more than 3 years, after the time the claim was filed (see section 10.1.1). All internal levels of appeal under the Plan must be exhausted before filing a legal action in court.

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

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

Guaranteed Renewability
Moda is required to renew coverage at the subscriber's option. Medicare eligibility is not a basis for non-renewal of this policy. Coverage may only be discontinued or non-renewed based on one or more of the following:

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

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

a. **A healthcare insurance plan not offered.** In any case in which Moda decides to discontinue offering one healthcare insurance plan offered in the individual market, that plan may be discontinued only if:
    i. Moda provides notice to each subscriber covered under that plan of such discontinuation at least 90 days prior to the date of the discontinuation of that plan
    ii. Moda offers each subscriber covered under that plan the option to purchase any other individual healthcare insurance plan currently being offered for members in such market
    iii. in exercising the option to discontinue coverage of a plan and in offering the option of coverage under other plans as described in the preceding bullet, Moda acts uniformly without regard to any health status-related factor of a current or prospective member
b. **Discontinuance of all healthcare insurance plans.**
    i. In general. In any case in which Moda elects to discontinue offering all healthcare insurance plans in the individual market in a state, these plans may be discontinued only if:
        A. Moda provides notice to the applicable state authority and to each subscriber of such discontinuation at least 180 days prior to the date of the expiration of such plans
        B. all healthcare insurance issued or delivered for issuance in the state in such market is discontinued and coverage under such health insurance plans in such market is not renewed

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

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

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

Nondiscrimination notice

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

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

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

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

888-217-2363 (TDD/TTY 711)

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

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

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

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

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

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

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

Dave Nesseler-Cass coordinates our nondiscrimination work:

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

moda HEALTH

DELTA DENTAL
Delta Dental of Oregon & Alaska

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

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

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

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

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

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

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

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

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

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

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

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

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

modahealth.com

39969758 (9/19)

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

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

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

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

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

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

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

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

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

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

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

moda HEALTH

DELTA DENTAL

Delta Dental of Oregon & Alaska

For help, call us directly at 844-274-9117
(En español: 888-786-7461)

P.O. Box 40384
Portland, OR 97240