

Texas Individual EPO Policy

Moda Select Silver 6400 Zero Cost Share Plan ($0 Deductible Plan)

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

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Health plans provided by Moda Health Plan, Inc.

ModaTXIndvEPObk-1-1-2022-HIX

moda HEALTH

NOTICES

GUARANTEED RENEWABILITY

Moda Health renews this individual plan on January 1 each year, including benefit and rate adjustments. Rates may also change when the family composition changes, or the subscriber moves into a different rating area, with new rates effective the first of the following month. This policy may be subject to non-renewal for dependents who surpass the maximum age limit for dependents.

RIGHT TO EXAMINE POLICY

The subscriber may return this policy to Moda Health 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 Health will hold the position as if no policy has been issued.

OTHER NOTICES

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company.

THIS IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. THE EMPLOYER DOES NOT BECOME A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM BY PURCHASING THIS POLICY, AND IF THE EMPLOYER IS A NON-SUBSCRIBER, THE EMPLOYER LOSES THOSE BENEFITS WHICH WOULD OTHERWISE ACCRUE UNDER THE WORKERS' COMPENSATION LAWS. THE EMPLOYER MUST COMPLY WITH THE WORKERS' COMPENSATION LAW AS IT PERTAINS TO NON-SUBSCRIBERS AND THE REQUIRED NOTIFICATIONS THAT MUST BE FILED AND POSTED.

In consideration of the completed and accepted enrollment application and timely payment of the required premiums, Moda Health agrees to provide the covered benefits as described in this policy.

The effective date of this policy is shown on the identification card and this policy may end based on the terms in When Coverage Ends section (see page 74).

IN-NETWORK BENEFITS

Only in-network services are covered in this policy except for emergency services, pharmacy prescription benefits and when out-of-network services are prior authorized. Otherwise, services out-of-network are not covered, and you will be responsible for paying the cost of out-of-network care.

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

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SECTION 1. WELCOME

Moda Health is pleased to provide individual health coverage to members through the Moda Select Silver 6400 CSV0 Plan. This policy is designed to provide members with important information about the Plan's benefits, limitations and procedures.

Members may direct questions to one of the numbers listed in section 2.1 or access tools and resources on Moda Health's personalized Member Dashboard at www.modahealth.com. The Member Dashboard is available 24 hours a day, 7 days a week allowing members to access plan information whenever it is convenient.

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

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

Coverage for the pediatric dental services as required by the Affordable Care Act are not provided by this policy. The only dental related coverage provided by this policy is described in section 8.4.8. To purchase the pediatric dental coverage required under the Affordable Care Act, contact the Health Insurance Marketplace.

IMPORTANT NOTE: IF CHILD ONLY COVERAGE

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

Insurance products provided by Moda Health Plan, Inc.

SECTION 2. MEMBER RESOURCES

2.1 CONTACT INFORMATION

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

Medical Customer Service Department
844-827-6571
En español 888-786-7461

Behavioral Health Customer Service Department
800-799-9391

Disease Management and Health Coaching
877-277-7281

Hearing Services Customer Service
TruHearing
866-202-2178

Pharmacy Customer Service Department
844-931-1780

Virtual Care preferred vendor
CirrusMD
cirrusmd.com/modahealth

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

Telecommunications Relay Service for the hearing impaired
711

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

Health Insurance Marketplace (the **Marketplace**)
800-318-2596
www.healthcare.gov

2.2 MEMBERSHIP CARD

After enrolling, members will receive ID (identification) cards that will include the identification 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

This Plan pays benefits only for services provided in the networks shown below. See Network Information (Section 6) for more detail about how networks work.

Medical Network
Moda Select

Network for spinal manipulation and outpatient rehabilitation
ASH

Pharmacy Network
Navitus

Travel Network
First Health
www.myfirsthealth.com

Vision network
VSP
www.vsp.com

2.4 CARE COORDINATION

2.4.1 Care Coordination

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

The Plan will coordinate access to a wide range of services spanning all levels of care depending on the member's needs. Having a nurse or behavioral health clinician available to coordinate these services ensures improved delivery of healthcare services to members and their professional providers.

2.4.2 Disease Management

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

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

Contact Disease Management and Health Coaching for more information.

2.4.3 Behavioral Health

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

2.5 OTHER RESOURCES

Additional member resources providing general information about the Plan can be found in Section 12 and Section 13.

Membership with Moda Health includes other advantages as well. Members have access to services, programs and tools to support their physical, mental and emotional health. These resources are not part of the policy, and they are not insurance. Members can access these extras through the Member Dashboard (see section 8.11).

SECTION 3. DEFINITIONS

Acquired Brain Injury means a neurological insult to the brain that is not hereditary, congenital, or degenerative. The injury to the brain has occurred after birth and results in a change in neuronal activity, which results in an impairment of physical functioning, sensory processing, cognition, or psychosocial behavior.

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

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

Authorization see Prior Authorization.

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

Autism Spectrum Disorder means a neurobiological disorder that includes autism, Asperger's syndrome, or pervasive developmental disorder, not otherwise specified. A neurobiological disorder means an illness of the nervous system caused by genetic, metabolic, or other biological factors.

Balance Billing means the difference between the maximum plan allowance and the provider's billed charge. Out-of-network providers may bill the member this amount, except when prohibited by law (see section 6.1.3). Balance billing is not a covered expense under the Plan.

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

Chemical Dependency means the abuse of, a psychological or physical dependence on, or an addiction to alcohol or a controlled substance. Chemical dependency does not mean an addiction to or dependency upon foods, tobacco or tobacco products.

Chemical Dependency Treatment Center means a facility that provides a program for the treatment of chemical dependency under a written treatment plan approved and monitored by a physician and that is:

a. Affiliated with a hospital under a contractual agreement with an established system for patient referral;
b. Accredited as a chemical dependency treatment center by the Joint Commission on Accreditation of Healthcare Organizations;
c. Licensed as a chemical dependency treatment program by the Texas Commission on Alcohol and Drug Abuse; or
d. Licensed, certified, or approved as a chemical dependency treatment program center by another state agency.

Coinsurance means the percentages of covered expenses to be paid by a member.

Congenital Condition means an illness or other anomaly existing at or before birth, whether acquired during development or by heredity.

Copay or **Copayment** means the fixed dollar amounts to be paid by a member to a provider when receiving a covered service.

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

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

Crisis Stabilization Unit means a 24-hour residential program that provides, usually for a short term, intensive supervision and highly structured activities to individuals who demonstrate a moderate to severe acute psychiatric crisis.

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

Dental Care means services or supplies provided to prevent, diagnose or treat diseases of the teeth and supporting tissues or structures, including services or supplies to restore the ability to chew and to repair defects that have developed because of tooth loss.

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

Dependent Child means a child who is under age 26 and who meets any of the following criteria:

a. The subscriber's biological child, stepchild, adopted child or foster child
b. The biological child, stepchild, adopted child or foster child of the subscriber's spouse or domestic partner
c. A child for whom the subscriber is seeking to adopt in a suit
d. A child for whom the subscriber has court-appointed legal guardianship
e. A child for whom the subscriber is required to provide coverage by a legal qualified medical child support order (QMCSO)
f. The subscriber's grandchild who, at the time of application, can be claimed as a dependent on the federal tax return

A child who meets one the criteria above, is age 26 or over and is incapable of self-support because of developmental disability or physical handicap that began before the 26th birthday will continue to be covered if written evidence of the child's incapacity is submitted within 31 days of the later of the child's 26th birthday or the policy effective date.

Developmental Delay means a significant variation in normal development as measured by appropriate diagnostic instruments and procedures, in one or more of the following areas:

a. Cognitive development
b. Physical development
c. Communication development
d. Social or emotional development
e. Adaptive development

Domestic Partner means a person joined with the subscriber in a partnership that has been registered under the laws of any federal, state or local government.

Effective Date means the following January 1 for members enrolled during open enrollment or the date as determined by the Health Insurance Marketplace after acceptance of an enrollment application. For new dependents, effective date means the date of birth for a newborn child, the date of the adoption decree for an adopted child, the date a subscriber becomes a party to the lawsuit for adoption, and the date of placement for a child placed for adoption or foster care. 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. All references to "effective date" mean 12:01 a.m. on the date that coverage under the policy begins.

Emergency Care means health care services provided in a hospital emergency facility, freestanding emergency medical care facility, or comparable emergency facility to evaluate and stabilize a medical condition of a recent onset and severity, including severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that the person's condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in one of the following:

a. Placing the person's health in serious jeopardy
b. Serious impairment to bodily functions
c. Serious dysfunction of a bodily organ or part
d. Serious disfigurement
e. In the case of pregnant woman, serious jeopardy to the health of the fetus

Emergency care provided at an out-of-network emergency care facility also includes 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 give informed consent.

Emergency Medical Screening Examination means the medical history, examination (which may include behavioral health assessment), related tests and medical determinations required to confirm the nature and extent of an emergency medical condition.

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

a. Involve a treatment for which scientific or medical assessment has not been completed, or the effectiveness of the treatment has not been generally established
b. Are available in the United States only as part of a clinical trial or research program for the illness or condition being treated

c. Are not provided by an accredited institution or provider within the United States or are provided by one that has not demonstrated medical proficiency in the provision of the service or supplies
d. Are not recognized by the medical community in the service area in which they are received
e. Involve a treatment for which the approval of one or more government agencies is required, but has not been obtained at the time the services and supplies are provided or are to be provided

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

a. A medication, device (supply) or biologic product for which the approval of one or more government agencies (such as the FDA) is required, but has not been obtained at the time the treatment is requested or administered
b. A treatment for which scientific or medical assessment has not been completed, or the effectiveness of the treatment has not been generally established
c. Is only available in the United States as part of a clinical trial or research program for the illness or condition being treated
d. Is the subject of an on-going phase I or phase II clinical trial, or is the research/ experimental/study/investigational arm of an on-going phase III clinical trial
e. Is used within a regimen that may be individually proven, but when utilized in combination, scientific literature does not support the use
f. Is used within a regimen that is proven in combination with other medications, but when utilized individually, scientific literature does not support the use

Genetic Information means information that is:

a. Obtained from or based on a scientific or medical determination of the presence or absence in an individual of a genetic characteristic; or
b. Derived from the results of a genetic test performed on an individual.

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

Home Health Agency means a business that provides home health services and is licensed, approved, or certified by the appropriate agency of the state in which it is located or is certified by Medicare as a supplier of home health care.

Home Health Care means the healthcare services for which benefits are provided under this policy when services are provided during a visit by a home health agency to members confined at home due to a sickness or injury requiring skilled health services on an intermittent, part-time basis.

Hospital means a short-term acute facility which:

a. Is duly licensed as a hospital by the state in which it is located and meets the standards established for such licensing, including those either accredited by the Joint Commission

on Accreditation of Healthcare Organizations or is certified as a Hospital Provider under Medicare;

b. Is primarily engaged in providing inpatient diagnostic and therapeutic care for the diagnosis, treatment and care of injury and sick persons by or under the supervision of physicians or behavioral health providers for compensation from its patients;
c. Has organized departments of medicine and major surgery, either on its premises or in facilities available to the hospital on a contractual prearranged basis, and maintains clinical records on all patients;
d. Provides 24-hour nursing care by or under the supervision of a registered nurse; and
e. Is not, other than incidentally, a skilled nursing facility, nursing home, custodial care home, health resort, spa or sanitarium, place for rest, place for the aged, place for the treatment of chemical dependency, hospice, or place for the provision of rehabilitative care.

Illness means a sickness, disease or medical condition that results in a covered service.

Implant means a material inserted or grafted into tissue.

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

In-network refers to providers that are contracted under Moda Health to provide care to members.

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

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

Life-threatening means a disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

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

MPA for out-of-network services is either a supplemental provider fee arrangement Moda Health may have in place or the amount calculated using one of the following methodologies, any of which may be used by Moda Health: a percentage of the Medicare allowable amount, a percentage of Resource-based relative value scale (RBRVS), a percentile of fees commonly charged for a given procedure in a given area, a percentage of the acquisition cost or a percentage of the billed charge.

MPA for emergency services received out-of-network, out-of-network ambulance, or out-of-network services in an in-network facility where the member is not able to choose the provider,

is based on the median in-network rate. Otherwise, the MPA is the amount determined by federal or state guidance.

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

In certain instances, when a dollar value is not available, Moda Health reviews the claim to determine a comparable code to the one billed. Once a comparable code is established, the claim is processed as described above.

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

Medical Condition means any physical or mental condition including one resulting from illness, injury (whether or not the injury is accidental), pregnancy or congenital malformation. Genetic information in and of itself is not a condition.

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

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

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

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

Medically necessary care does not include custodial care.

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

More information about medical necessity can be found in the General Exclusions (Section 9).

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

Mental Health Care means any of the following:

a. The diagnosis or treatment of a mental disease, disorder, or condition listed in the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association (DSM), as revised, or any other diagnostic coding system used by Moda Health, whether the cause of the disease, disorder, or condition is physical, chemical, or mental in nature or origin;
b. The diagnosis or treatment of any symptom, condition, disease, or disorder by a physician, behavioral health practitioner or professional other provider (or by any person working under the direction or supervision of a physician, behavioral health practitioner or other professional provider) when the eligible expense is one of the following:
    i. Individual, group, family, or conjoint psychotherapy
    ii. Counseling
    iii. Psychoanalysis
    iv. Psychological testing and assessment
    v. The administration or monitoring of psychotropic medications
    vi. Hospital visits or consultations in a facility
c. Electroconvulsive treatment
d. Psychotropic medications
e. Any of the services above, performed in or by a hospital, other facility provider, or other licensed facility or unit providing such care

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

Moda Health refers to Moda Health Plan, Inc.

Network means a group of providers who contract to provide healthcare to members at negotiated rates. Such groups are called Exclusive Provider Organizations (EPOs) and provide in-network services in their specific service areas.

Orthotic Device means a custom-fitted or custom-fabricated medical device that is applied to a party of the body to correct a deformity, improve function, or relieve symptoms of a disease.

Out-of-network refers to providers that are not contracted under Moda Health to charge discounted rates to members. Out-of-network services are not preferred providers and are generally not covered by the Plan.

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

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

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

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

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

Preferred Provider means a health care provider, or an organization of health care providers, who contract to provide medical care or health care covered by the policy.

Prior Authorization or **Prior Authorized** refers to obtaining approval by Moda Health before the date of service. A complete list of services and medications that require prior authorization is available on the Member Dashboard or by contacting Customer Service. Failure to obtain required authorization will result in denial of benefits or a penalty (see section 7.1).

Professional Provider means any state-licensed or state-certified healthcare professionals, when providing medically necessary services within the scope of their licenses or certifications. In all cases, the services must be covered under the Plan to be eligible for benefits.

Prosthetic Device means an artificial device or appliance designed to replace in whole or in part an arm or a leg.

Provider means an entity, including a facility, a medical supplier, a program or a professional provider, that is providing medically necessary services for diagnosis or treatment of illness or injury. Such services must be within the scope of the provider's state license, certification or registry.

Psychiatric Day Treatment Facility means an institution which is appropriately licensed and is accredited by the Joint Commission on Accreditation of Healthcare Organizations as a psychiatric day treatment facility for the provision of mental health care and serious mental illness services to members for periods of time not to exceed eight hours in any 24-hour period. Any treatment in a psychiatric day treatment facility must be certified in writing by the attending physician or mental health provider to be in lieu of hospitalization.

Reconstructive Surgery for Craniofacial Abnormalities means surgery to improve the function of, or to attempt to create a normal appearance of, an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections, or disease.

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

Residential Treatment Center for Children and Adolescents means a child-care institution which is appropriately licensed and accredited by the Joint Commission on Accreditation of Healthcare Organizations or the American Association of Psychiatric Services for Children as a residential treatment center for the provisions of mental health care and serious mental illness services for emotionally disturbed children and adolescents.

Serious Mental Illness means the following psychiatric illnesses defined by the American Psychiatric Association in the Diagnostic and Statistical Manual (DSM):

a. Bipolar disorders (hypomanic, manic, depressive, and mixed)
b. Depression in childhood and adolescence
c. Major depressive disorders (single episode or recurrent)
d. Obsessive-compulsive disorders
e. Paranoid and other psychotic disorders
f. Schizo-affective disorders (bipolar or depressive)
g. Schizophrenia

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

Skilled Nursing Facility means a facility:

a. Licensed under applicable laws to provide inpatient care under the supervision of a medical staff or medical director;
b. Which provides continuous 24-hour a day nursing service supervised by registered nurses; and
c. Which is not, other than incidentally, a place for drug addicts, alcoholics or the mentally ill.

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

Teledentistry Dental Service means a health care service delivered by a dentist, or a health professional acting under the delegation and supervision of a dentist, acting within the scope of the dentist's or health professional 's license or certification to a member at a different physical location than the dentist or health professional using telecommunications or information technology.

Telehealth means a health service, other than a telemedicine medical service, delivered by a professional provider licensed, certified, or otherwise entitled to practice in Texas and acting within the scope of the professional provider's license, certification, or entitlement to a patient at a different physical location than the professional provider using telecommunications or information.

Telemedicine means a health care service delivered by a physician licensed in Texas, or a professional provider acting under the delegation and supervision of a physician licensed in Texas, and acting within the scope of the physician's or professional provider's license to a patient at a different physical location than the physician or professional provider using telecommunications or information technology.

First Health means 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 residing outside the primary service area. To find a First Health provider, members can search providers at www.myfirsthealth.com.

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

VSP refers to the vision care network of providers.

SECTION 4. SCHEDULE OF BENEFITS

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

It is important to also check the Covered Expenses (Section 8) for more details about any limitations or requirements. Link directly there from the Details column.

All services must be provided by an in-network provider in order to be covered, except in the case of a medical emergency, pharmacy prescription benefits or when out-of-network care has been prior authorized.

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 7.1). An explanation of important terms is found in Section 3.

Cost sharing is the amount members pay. See 0 for more information, including an explanation of deductible and out-of-pocket maximum. Members must use in-network providers.

All "annual" or "per year" benefits 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.

	In-Network Benefits	**Out-of-Network Benefits**
Annual deductible per member	**$0**	**N/A**
Maximum annual deductible per family	**$0**	
Annual out-of-pocket maximum per member	**$0**	
Maximum annual out-of-pocket maximum per family	**$0**	

Services	**Cost Sharing** (Deductible applies unless noted differently)		**Section in Handbook & Details**
	In-network	**Out-of-network**	
Urgent & Emergency Care			
Ambulance Transportation	0%		Section 8.2.1

Services	Cost Sharing (Deductible applies unless noted differently)		Section in Handbook & Details
	In-network	Out-of-network	
Emergency Room Facility (includes ancillary services)	0%		Section 8.2.2
ER professional or ancillary services billed separately	0%		
Urgent Care Office Visit	$0 per visit	Not covered, except through travel network	Section 8.2.3
Preventive Services			
Services as required under the Affordable Care Act, including the following:	No cost sharing	Not covered	Section 8.3 Age/frequency limits may apply
Colonoscopy	No cost sharing	Not covered	Section 8.3.3 One per 10 years, age 45+
Contraception	No cost sharing	Not covered	Section 8.3.4
Human Papillomavirus and Cervical Cancer Testing	No cost sharing	Not covered	Section 8.3.5
Immunizations	No cost sharing	Not covered	Section 8.3.6
Mammogram and Breast Exam	No cost sharing	Not covered	Section 8.3.7 and 8.3.1 Mammogram: One per year, age 35+ Breast Exam: One per year, age 18+
Osteoporosis Detection and Prevention	No cost sharing	Not covered	Section 8.3.8
Pediatric Screenings	No cost sharing	Not covered	Section 8.3.9
Preventive Health Exams	No cost sharing	Not covered	Section 8.3.10 6 visits in first year of life 7 exams age 1- 4 One per year, age 5+
Tobacco Cessation Treatment	No cost sharing	Not covered	Section 8.3.12
Other Preventive Services including:			
Cardiovascular Disease Screening	No cost sharing	Not covered	Section 8.3.2 Age/frequency limits apply
Diagnostic X-ray & Lab	0%	Not covered	Section 8.3.10

Services	Cost Sharing (Deductible applies unless noted differently)		Section in Handbook & Details
	In-network	Out-of-network	
Prostate Rectal Exam	No cost sharing	Not covered	Section 8.3.11 One per year, age 50+
Prostate Specific Antigen (PSA) Test	No cost sharing	Not covered	Section 8.3.11 One per year, age 50+
Outpatient Services			
Amino Acid-Based Elemental Formulas	0%	Not covered	Section 8.4.1
Anticancer Medication	0%	Not covered	Section 8.4.2
Applied Behavior Analysis	0%	Not covered	Section 8.4.3
Biofeedback	$0 per visit	Not covered	Section 8.4.4 10 visit lifetime maximum
Chemical Dependency Services	$0 per visit	Not covered	Section 8.4.5
Dental Injury	0%	Not covered	Section 8.4.8
Diabetes Care	0%	Not covered	Section 8.4.10 Supplies covered under DME and Pharmacy benefits
Diagnostic Procedures, including x-ray and lab	0%	Not covered	Section 8.4.11
Infusion Therapy for Home Use	0%	Not covered	Section 8.4.15 Certain medications from preferred suppliers covered under specialty pharmacy benefit.
Kidney Dialysis	0%	Not covered	Section 8.4.16
Mental Health Services	$0 per visit	Not covered	Section 8.4.18
Office and Home Visits			Section 8.4.20 See also Telemedicine Telehealth and Virtual Care under Other Services
PCP Visits	$0 per visit	Not covered	
Specialist Visits	$0 per visit	Not covered	
Rehabilitation & Habilitation (Physical, occupational, and speech therapy, and spinal manipulation)	$0 per visit	Not covered	Section 8.4.21 35 sessions per year. Limits apply separately to rehabilitation and habilitation services (N/A to mental health/ chemical dependency)
Surgery and Invasive Diagnostic Procedures	0%	Not covered	Section 8.4.22
Therapeutic Injections	0%	Not covered	Section 8.4.23
Therapeutic Radiology	0%	Not covered	Section 8.4.24

Services	Cost Sharing (Deductible applies unless noted differently)		Section in Handbook & Details
	In-network	Out-of-network	
Inpatient & Residential Facility Care			
Chemical Dependency Detoxification	0%	Not covered	Section 8.5.1
Diagnostic Procedures, including x-ray and lab	0%	Not covered	Section 8.5.2
Hospital Physician Visit	0%	Not covered	Section 8.5.4
Inpatient Care	0%	Not covered	Section 8.5.3
Rehabilitation & Habilitation (Physical, occupational, and speech therapy)	0%	Not covered	Section 8.5.7
Residential Mental Health & Chemical Dependency Treatment Programs	0%	Not covered	Section 8.5.8
Skilled Nursing Facility Care	0%	Not covered	Section 8.5.9 25 days per year
Transplants			Section 8.5.13
Authorized transplant facilities	0%	N/A	
Other facilities	Not covered		
Maternity Services			
Breastfeeding Support/Counseling and Supplies	No cost sharing	Not covered	Section 8.6.1
Complications of Pregnancy	0%	Not covered	Section 8.6.2
Maternity	0%	Not covered	Section 8.6
Other Services			
Acquired Brain Injury	0%	Not covered	Section 8.7.1
Durable Medical Equipment, Supplies & Appliances	0%	Not covered	Section 8.7.2 Limits apply to some DME, supplies, appliances
Home Health care	0%	Not covered	Section 8.7.3 Annual maximum limit of 60 visits
Hospice Care		Not covered	Section 8.7.4
Home Care	0%		
Inpatient Care	0%		

Services	Cost Sharing (Deductible applies unless noted differently)		Section in Handbook & Details
	In-network	Out-of-network	
Telemedicine, Telehealth and Virtual Care Visits			Section 8.7.5
Virtual Care Through CirrusMD	No cost sharing	N/A	Log on via modahealth.com/cirrusmd
Other providers	$0 per visit	Not covered	
Pharmacy			
Prescription Medication	A member who uses an out-of-network pharmacy must pay any amounts charged above the MPA		Section 8.8
Retail Pharmacy			Up to 30-day supply per prescription
Value	$0		
Select	$0		
Preferred	0%		
Nonpreferred	0%		
Mail Order Pharmacy		Must use a designated mail order pharmacy	Up to 90-day supply per prescription
Value	$0		
Select	$0		
Preferred	0%		
Nonpreferred	0%		
Specialty Pharmacy		Must use a designated specialty pharmacy	Up to 30-day supply per prescription for most medications
Preferred Specialty	0%		
Nonpreferred Specialty	0%		
Anticancer Medication	0%	0% Mail order and specialty must use Moda-designated pharmacies	

Services	Cost Sharing (Deductible applies unless noted differently)		Section in Handbook & Details
	In-network	Out-of-network	
Vision Care			
Pediatric Vision Care			Section 8.9.1
Exam	No cost sharing	Not covered	One per year
Lenses & frames or contacts	No cost sharing	Not covered	One pair per year Frames from the Otis & Piper collection only
Low vision evaluation	No cost sharing	Not covered	Once every year
Low vision services	No cost sharing	Not covered	4 visits every 5 years for follow up care
Low vision aids	No cost sharing	Not covered	One low vision aid per year and one pair of high power spectacles per year
Adult Vision Care			Section 8.9.2
Exam	$0 per visit	Not covered	One per year
Hearing Coverage			
Hearing Services			Section 8.10
Hearing Exams	$0 per visit	Not covered	Hearing exam once every year
Hearing Aids	0%	Not covered	Hearing aids once every 3 years.

SECTION 5. PAYMENT & COST SHARING

5.1 DEDUCTIBLES

Every year, members will have to pay some expenses before the Plan starts paying. This is called meeting or satisfying the deductible. Members must pay the entire covered expenses until they have spent the deductible amount unless the Plan specifically states otherwise. Then the Plan begins sharing costs with the member. Once a family member has met the 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 the Schedule of Benefits. If more than one member of a family is covered, each individual member only has to pay the per member deductible until the total family deductible is reached.

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

5.2 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.

Prior authorization penalty, payments made by manufacturer discounts and/or copay assistance programs do not count toward the out-of-pocket maximum.

Members are responsible for disallowed charges, which may include amounts over the MPA and expenses incurred due to brand substitution. They do not accrue toward the out-of-pocket maximum and members must pay for them even after the out-of-pocket maximum is met.

5.3 PAYMENT

Expenses allowed by Moda Health are based upon the maximum plan allowance (MPA), which is defined in Section 3. Depending upon the Plan provisions, cost sharing may apply.

Out-of-network care is not covered. The only exceptions are emergency care and pharmacy prescription benefits, or when prior authorized by Moda Health. For covered services provided out-of-network, members may be responsible for any amount over the MPA.

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

5.4 EXTRA-CONTRACTUAL SERVICES

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

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

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

SECTION 6. NETWORK INFORMATION

Benefits are available for services delivered by in-network providers. Remember to ask providers to send any lab work or x-rays to an in-network facility. Services a member receives in an in-network facility may be provided by physicians, anesthesiologists, pathologists, radiologists or other professionals who are out-of-network providers. When a member receives services from these out-of-network providers, any amounts charged above the MPA may be the member's responsibility.

Members may choose an in-network provider by using Find Care on the Member Dashboard or by contacting Customer Service for assistance. Member ID cards will identify the applicable network.

Ask if the provider (both professional provider and facility) is participating with the specific network listed below. It is the member's responsibility to check and make sure a provider is part of the network, even when the primary care physician (PCP) or other in-network provider has directed or referred the member to that provider.

6.1 GENERAL NETWORK INFORMATION

Members must use in-network providers in order for services to be covered by the Plan.

Network

a. Medical network is Moda Select in Hays, Travis and Williamson counties
b. Network for spinal manipulation or outpatient rehabilitation is ASH in Hays, Travis and Williamson counties
c. Pharmacy network is Navitus
d. Vision network is VSP

6.1.1 Coverage Outside the Service Area for Certain Children

Enrolled children who reside outside of the service area are covered for emergency care. Enrolled children under a Qualified Medical Child Support Order (QMCSO) who are residing in the United States but outside of the service area will also receive out-of-area benefits for non-emergency care.

Children eligible for out-of-area benefits will receive the best benefit by using a travel network provider as described in section 6.1.2 if one is available. When a child under a QMCSO is added, members must contact Customer Service to provide the documentation, including the child's address. The enrolled child will be eligible for out-of-area coverage on the first day of the month following the date documentation is received and the address is updated in Moda Health's system.

6.1.2 Travel Network

Members traveling outside of the service area may receive benefits by using a travel network provider. A travel network is only considered in-network if members are outside the service area and the travel is not for the purpose of receiving treatment or benefits. The travel network is not available to members who are temporarily residing outside the primary service area.

Travel Network
First Health

Members may find a travel network provider by using Find Care on the Member Dashboard or by contacting Customer Service for assistance.

6.1.3 Out-of-Network Care

When members choose healthcare providers that are not in-network, services generally are not covered.

Moda Health will work with the PCP to refer members to in-network providers whenever possible because in-network providers have agreed to cooperate in Moda Health's quality assurance and utilization review programs.

Out-of-network services are covered in certain cases:

a. Out-of-network services that are medically necessary but not available through an in-network provider and these services are authorized by Moda Health
b. When a member is receiving emergency care at an in-network facility and is not able to choose an in-network provider for ancillary services such as diagnostic testing, anesthesia or laboratory services, or treatment required to stabilize the member
c. When a member is receiving emergency care at an out-of-network facility, including post-stabilization services 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 give informed consent
d. When a member is receiving non-emergency care in an in-network facility and is not able to choose an in-network provider for services such as equipment and devices, telemedicine services, imaging services, laboratory services and preoperative and postoperative services

If a member receives care from an out-of-network provider for a medical emergency at an in-network facility, for a medical emergency at an out-of-network facility, for non-emergency services and supplies at an in-network facility or for other healthcare when authorized and approved by Moda Health, the benefit will be based on the maximum plan allowance for those services. Members will be responsible for the applicable cost sharing and an out-of-network provider cannot balance bill members except when permitted by law.

6.1.4 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 providers after normal office hours should call their regular office number.

6.2 USING FIND CARE

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

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

6.2.1 Primary Care Providers

To find a PCP:

a. Choose a “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.

6.2.2 DME Providers

Find a preferred DME provider:

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

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

SECTION 7. PRIOR AUTHORIZATION

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

When a professional provider suggests a type of service requiring authorization (see section 7.1.1), the member should ask the provider to contact Moda Health for prior authorization. Authorization for emergency hospital admissions must be obtained by calling Moda Health within 48 hours of the hospital admission (or as soon as reasonably possible). The hospital, professional provider and member are notified of the outcome of the authorization process by phone or email first and then by letter.

7.1 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 $500 per occurrence will be applied to covered charges before regular plan benefits are computed. The member will be responsible for any charges not covered because of noncompliance with authorization requirements.

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

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.

Prior authorization is not required for an emergency admission.

7.1.1 Services Requiring Prior Authorization

Many services within the following categories may require prior authorization:

a. Inpatient services and residential programs
b. Outpatient services
c. Rehabilitation (Physical, occupational, speech therapy. Spinal manipulation does not require prior authorization)
d. Imaging services
e. Infusion therapy
f. Disease management for pain
g. Medications

A full list of services and supplies requiring prior authorization is on the Moda Health website at www.modahealth.com/texas. This list is updated periodically, and members should ask their

provider to check to see if a service or supply requires authorization. A member may obtain authorization information by contacting Customer Service at 844-827-6571. For mental health or chemical dependency services, contact Behavioral Health Customer Service at 800-799-9391.

For an elective inpatient hospital admission, the call for prior authorization should be made at least two business days before the member is admitted unless it will delay emergency care. In an emergency, prior authorization should take place within two business days after admission, or as soon after as reasonably possible.

7.1.2 Prior Authorization Review

Moda Health will review prior authorization requests for procedures and supplies and notify the provider and member of the outcome using the following timelines:

a. Within 3 business days when the member is not hospitalized, and the request is not related to urgent care
b. Within one business day when the member is hospitalized
c. No later than on hour after receiving the request for poststabilization care following emergency treatment or a life-threatening condition
d. Within 3 business days for acquired brain injury requests
e. No later than 30 days before the date the prescription medications or intravenous infusions will be discontinued for a member who is receiving the medications or infusions

Moda Health will not deny or reduce payment of services or supplies that are authorized based on medical necessity unless the provider has materially misrepresented the proposed services or supplies, or has substantially failed to perform the proposed services.

7.1.3 Prior Authorization Limitations

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

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

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

7.1.4 Out-of-Network Services

When Moda Health has authorized use of an out-of-network provider, the member is responsible for ensuring that the provider contacts Moda Health for prior authorization of any services that require it. Services not authorized in advance will be denied, and the full charge will be the member's responsibility.

Any amounts that are member responsibility due to not obtaining a prior authorization do not apply toward the Plan's deductible or out-of-pocket maximum.

7.1.5 Second Opinion

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

7.1.6 Renewal of a Prior Authorization Request

Moda Health will accept requests for renewal of an existing prior authorization beginning 60 days from the date of that the existing prior authorization is set to expire. Upon receipt of a request for renewal of an existing prior authorization, Moda Health will review the request and issue a determination indicating whether the service is prior authorized before the existing authorization expires.

SECTION 8. COVERED EXPENSES

The Plan covers services and supplies listed when medically necessary for diagnosis and/or treatment of a medical condition, as well as certain preventive services. The details of the different types of benefits and the conditions, limitations and exclusions are described in the sections that follow. An explanation of important terms is found in Section 3.

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.

Many services require prior authorization. A complete list is available on the Member Dashboard or by contacting Customer Service. Sometimes the authorization will require the member to use a certain provider for the service. Failure to obtain required prior authorization may result in denial of benefits based on utilization review or a penalty (see section 7.1).

8.1 WHEN BENEFITS ARE AVAILABLE

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

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

Benefits are only payable after the service or supply has been provided. If a limitation or exclusion applies to an otherwise covered service, benefits will not be paid.

All services must be provided by an in-network provider in order to be covered, except in the case of a medical emergency, pharmacy prescription medications or when out-of-network care has been prior authorized. If a member cannot reasonably reach an in-network provider for emergency care, services from an out-of-network provider will be covered at the in-network rate.

8.2 URGENT & EMERGENCY CARE

In the case of a medical emergency, services may be provided by an in-network or out-of-network provider. If a member cannot reasonably reach an in-network provider, the policy will provide benefits for emergency care (as defined in Section 3) received from an out-of-network provider to the same extent as if care was provided by an in-network provider.

If a member cannot reasonably reach an in-network provider, Moda Health shall provide reimbursement for the following emergency care services at the maximum plan allowance or at an agreed rate at the in-network level of benefits until the member can reasonably be expected to an in-network provider:

a. a medical screening examination or other evaluation required by state or federal law to be provided in the emergency facility of a hospital that is necessary to determine whether a medical emergency condition exists

b. necessary emergency care services, including the treatment and stabilization of an emergency medical condition
c. services originating in a hospital emergency facility or freestanding emergency medical care facility following treatment or stabilization as part of an outpatient observation or an inpatient or outpatient stay

Follow-up care provided by an out-of-network provider will be covered at the in-network benefit level only to the extent it is medically necessary, and until the member can return to the service area to receive treatment from an in-network provider. The out-of-network provider may not bill the member, and the member will not have financial responsibility for, an amount greater than the applicable cost sharing and deductible under the policy.

Non-emergency care when traveling outside the United States is covered.

8.2.1 Ambulance Transportation

Ambulance transportation, including local ground transportation by state certified ambulance and certified air ambulance transportation, is covered for medically necessary transport to the nearest facility that has the capability to provide the necessary treatment. Out-of-network ground ambulance providers may bill members for charges in excess of the maximum plan allowance.

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

8.2.2 Emergency Care

Members are covered for emergency care (as defined in Section 3) worldwide. A member who believes he or she has a medical emergency should call 911 or seek care from the nearest appropriate provider.

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

Prior authorization is not required for emergency care such as emergency medical screening exams or treatment to stabilize an emergency medical condition, whether in-network or out-of-network. Emergency care should be reported to the PCP as soon as possible.

If a member's condition requires hospitalization in an out-of-network facility, the attending physician and Moda Health's medical director will monitor the condition and determine when the transfer to an in-network facility can be made. The Plan does not provide benefits for care beyond the date the attending physician and Moda Health's medical director determine the member can be safely transferred.

The following are examples of services that are not for treatment of emergency medical conditions, and members should not go to an emergency care facility for such services:

a. Urgent care or immediate care visits
b. Care of chronic conditions, including diagnostic services
c. Preventive services

d. Elective surgery and/or hospitalization
e. Outpatient office visits and related services for a medical or mental health condition

8.2.3 Urgent Care

Short-term medical care provided by an urgent care facility for minor but urgent medical conditions that do not pose a significant threat to life or health at the time the services are rendered is covered. The member must be actually examined by a professional provider. Urgent care is not covered out-of-network. Urgent care outside Texas is covered when using the travel network (see section 6.1.2).

Visits as walk-in clinics and immediate care facilities are covered under the office visit benefit (section 8.4.20). Immediate care, express care or walk-in care refers to primary care or specialist care that is on demand and does not require an appointment. Facilities that provide such on-demand care are not urgent care facilities unless their claim billing includes the CMS Place of Service code that is specific for an urgent care facility.

8.3 PREVENTIVE SERVICES

As required under the Affordable Care Act (ACA), certain services will be covered at no cost to the member. Moda Health will use reasonable medical management techniques to determine coverage limitations where permitted by the ACA. :

a. Evidence-based services rated A or B by the United States Preventive Services Taskforce (USPSTF) (www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/)
b. Immunizations recommended by the Advisory Committee on Immunization Practices of the Center for Disease Control and Prevention (ACIP)(www.cdc.gov/vaccines/acip/recs/)
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 adopts a new or revised recommendation, the Plan has up to one year before coverage of the related services must be available and effective.

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

8.3.1 Breast Exams

Breast exams are limited to once per year for women 18 years of age and older. Breast exams for the purpose of screening or diagnosis in symptomatic or designated high risk members are also covered when deemed necessary by a professional provider. These services are covered under the office visit benefit level if not performed within the Plan's age and frequency limits for preventive screening.

8.3.2 Cardiovascular Disease Screening

Certain tests for early detection of cardiovascular disease for a member who is:

a. A male older than 45 years of age and younger than 76 years of age
b. A female older than 55 years of age and younger than 76 years of age

The member must be a diabetic or have a risk of developing coronary heart disease based on a score derived using the Framingham Heart Study coronary prediction algorithm, that is intermediate or higher.

Benefits for atherosclerosis and abnormal artery structure and function every 5 years, performed by a laboratory that is certified by a national organization recognized by the commissioner:

a. Computed tomography (CT) scanning measuring coronary artery calcification
b. Ultrasonography measuring carotid intima-media thickness and plaque

8.3.3 Colorectal Cancer Screening

The following services, including related charges, for members age 45 and over who are at normal risk of developing colon cancer:

a. One colonoscopy, including polyp removal, and pre-surgical exam or consultation every 10 years
b. One fecal occult blood test every year
c. One fecal DNA test every 3 years
d. One flexible sigmoidoscopy and pre-surgical exam or consultation every 5 years
e. One double contrast barium enema every 5 years

These screening timelines align with the USPSTF recommendations for individuals not at high risk for colorectal cancer. Screening procedures performed more frequently must be determined medically necessary. A follow-up colonoscopy is covered at no cost sharing if the results of the initial colonoscopy or other screening tests are abnormal.

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

Colorectal cancer screening is covered at no cost sharing when a member meets the criteria in the USPSTF recommendation for colorectal cancer screening. When a member's situation does not fit the USPSTF A or B rated recommendation for colorectal cancer screening, benefits will be at the medical benefit level.

For members who are at high risk for colorectal cancer, including those with a family medical history of known genetic disorders that predispose them to a high lifetime risk of colorectal cancer (such as Lynch syndrome), a prior occurrence of colorectal cancer or an adenomatous polyp, or a personal history of inflammatory bowel disease, 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 criteria for the USPSTF A or B rated recommendation.

8.3.4 Contraception

All FDA approved contraceptive methods, including sterilization, and counseling are covered when prescribed by a professional provider. When using the most cost-effective option (e.g., generic instead of brand name), women's contraception will be covered with no cost sharing. If the cost-effective contraception is deemed medically inadvisable by the member's provider, the Plan will cover an alternative prescribed by the provider. Over the counter contraceptives are covered under the Pharmacy benefit (section 8.8). Prior authorization and step therapy requirements do not apply. Surgery to reverse elective sterilization (vasectomy or tubal ligation) is not covered.

8.3.5 Human Papillomavirus and Cervical Cancer Testing

Coverage is provided for members enrolled in the plan who are 18 years of age or older for expenses incurred for an annual, medically recognized diagnostic examination for the early detection of ovarian and cervical cancer.

Coverage includes, at minimum, a Cancer Antigen (CA 125) blood test and a conventional Pap smear screening or a screening using liquid-based cytology methods, as approved by the FDA, alone or in combination with a test approved by the FDA for the detection of the human papillomavirus and other tests or screenings approved by the FDA for the detection of ovarian cancer.

8.3.6 Immunizations

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

Examples of covered immunizations include:

a. Diphtheria
b. Haemophilus influenzae type B
c. Hepatitis B
d. Measles
e. Mumps
f. Pertussis
g. Polio
h. Rubella
i. Tetanus
j. Varicella and
k. Other immunizations required by law for a child

8.3.7 Mammograms

Diagnostic and screening mammograms by low dose mammography, including digital mammography and beast tomosynthesis (3D mammography), for the presence of breast cancer are covered. Screening mammograms are covered once per year for members age 35 years of age and older. Age requirements do not apply to diagnostic mammograms and they are available when medically necessary to members of any age.

Diagnostic breast imaging including mammography, ultrasound imaging or magnetic resonance imaging for the purpose of screening or diagnosis in symptomatic or designated high risk members are also covered when deemed necessary by a professional provider.

8.3.8 Osteoporosis Detection and Prevention

The Plan covers screening for osteoporosis with bone measurement testing to prevent osteopathic fractures in:

a. women 65 years and older
b. postmenopausal women younger than 65 years who are at increased risk of osteoporosis, as determined by a formal clinical risk assessment tool
c. postmenopausal women who are not receiving estrogen replacement therapy and are not determined to be at increased risk of osteoporosis

In addition, coverage also includes bone mass measurement for the detection of low bone mass and to determine a qualified individual's risk of osteoporosis and fractures associated with osteoporosis.

Qualified individual means:

a. An individual with:
    i. Vertebral abnormalities
    ii. Primary hyperparathyroidism; or
    iii. A history of bone fractures; or
b. An individual who is:
    i. Receiving long-term glucocorticoid therapy; or
    ii. Being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy

8.3.9 Pediatric Screenings

At the frequency and age recommended by HRSA or USPSTF, including:

a. Screening for hearing loss in newborn infants through the date the child is 30 days old and medically necessary diagnostic follow-up care related to the screening from birth through the date the child is 24 months old
b. Routine vision screening to detect amblyopia, strabismus and defects in visual sharpness in children age 3 to 5
c. Developmental and behavioral health screening
d. Screening for autism spectrum disorder for children age 18 and 24 months (see section 8.4.3)

8.3.10 Preventive Health Exams

Covered according to the following schedule based on USPSTF and HRSA guidelines:

a. Newborn: 1 hospital visit
b. Well-baby visits and care (after newborn's initial examination and discharge from the hospital): 6 well -baby visits during the first year of life
c. Age 1 to 4: 7 exams
d. Age 5 and above: 1 exam every year

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

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

8.3.11 Prostate Testing – Coverage for Certain Tests

Prostate rectal exam and PSA test are subject to the standard cost sharing.

Covered according to the following schedule:

a. An annual medically recognized diagnostic physical examination for the detection of prostate cancer; and
b. A PSA test used for the detection of prostate cancer for a member who:
    i. Is at least 50 years of age and is asymptomatic; or
    ii. Is at least 40 years of age and has a family history of prostate cancer or another prostate cancer risk factor

8.3.12 Tobacco Cessation

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

A tobacco cessation program can provide an overall treatment program that follows the United States Public Health Service guidelines for tobacco use cessation. Members may have more success with a coordinated program.

8.4 OUTPATIENT SERVICES

Many outpatient services require prior authorization (see section 7.1). All services must be medically necessary.

8.4.1 Amino Acid-Based Elemental Formulas

Amino acid-based elemental formulas, regardless of the formula delivery method, used for the diagnosis and treatment of:

a. Immunoglobulin E and non-immunoglobulin E mediated allergies to multiple food proteins
b. Severe food protein-induced enterocolitis syndromes
c. Eosinophilic disorders, as evidenced by the results of biopsy
d. Disorders affecting the absorptive surface, functional length, and motility of the gastrointestinal tract

8.4.2 Anticancer Medication

Prescribed anticancer medications, including oral, intravenous (IV) or injected medications, are covered. Most anticancer medications may require prior authorization and be subject to specific benefit limitations. Specialty anticancer medications require delivery by a Moda-designated specialty pharmacy (see section 8.8.5). For some anticancer medications, members may be required to enroll in programs to ensure proper medication use and/or reduce the cost of the medication. More information is available on the Member Dashboard or by contacting Customer Service.

8.4.3 Applied Behavior Analysis (ABA)

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

Providers providing treatment prescribed under the individualized treatment plan must be a health care practitioner:

a. Who is licensed, certified, or registered by an appropriate agency of the state of Texas
b. Whose professional credential is recognized and accepted by an appropriate agency of the United States
c. Who is certified as a provider under TRICARE military health system

Treatment may include services such as:

a. Evaluation and assessment services
b. Screening at 18 and 24 months
c. Applied behavioral analysis
d. Behavior training and behavior management
e. Speech therapy
f. Occupational therapy
g. Physical therapy
h. Medications or nutritional supplements used to address symptoms of autism spectrum disorder.

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

8.4.4 Biofeedback

Covered expenses for biofeedback therapy services are limited to treatment of tension or migraine headaches or urinary incontinence. Covered visits are subject to a lifetime limit.

8.4.5 Chemical Dependency Services

Services for assessment and treatment of chemical dependency in an outpatient treatment program that meets the definitions in the Plan (see Section 3) are covered. Quantitative or non-quantitative limitations applied to chemical dependency services will not be more restrictive than limitations imposed on coverage of benefits for medical or surgical expenses.

8.4.6 Clinical Trials

Routine patient costs incurred by qualified individuals who participate in an approved clinical trial are covered.

Approved clinical trials means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of a life-threatening illness and is approved by one of the following agencies:

a. The Centers for Disease Control and Prevention of the United States Department of Health and Human Services
b. The National Institutes of Health
c. The United States Food and Drug Administration
d. The United States Department of Defense
e. The United States Department of Veteran Affairs
f. An institutional review board of an institution in this state that has an agreement with the Office for Human Research Protections of the United States Department of Health and Human Services

Routine Costs do not include:

a. The cost of an investigational new drug or device that is not approved for any indication by the United States Food and Drug Administration, including a drug or device that is the subject of the clinical trial
b. The cost of a service that is not a health care service, regardless of whether the service is required in connection with participation in a clinical trial
c. The cost of a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis
d. A cost associated with managing a clinical trial
e. The cost of a health care service that is specifically excluded from coverage under this Policy

8.4.7 Cochlear Implants

Cochlear implants are covered when medically or audiologically necessary and prior authorized. Benefits include an external speech processor and controller with necessary components replacement every 3 years. Treatment related to cochlear implants, including coverage for habilitation and rehabilitation as necessary for educational gain, is covered.

8.4.8 Dental Injury

Dental services are not covered, except for treatment of accidental injury to un-restored natural teeth and supporting tissues. 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. A broken tooth resulting from biting or chewing food is not an accidental injury.
b. Treatment is completed within 24 months of the date of the initial treatment
c. Treatment is medically necessary and is provided by a physician or dentist while the member is covered by this policy
d. Treatment is limited to that which will restore teeth to a functional state

Implants and implant related services are not covered.

8.4.9 Dental Procedures, Facility Charges

If a serious medical condition makes a dental procedure risky, or if the member cannot be safely and effectively treated in a dental office because of a physical or developmental disability,

general anesthesia services and related facility charges are covered when the dental procedure is provided in a hospital or outpatient clinic. Services must be prior authorized.

8.4.10 Diabetes Care

For members who are diagnosed with one of the following:

a. Insulin dependent or noninsulin dependent diabetes
b. Elevated blood glucose levels induced by pregnancy
c. Another medical condition associated with elevated blood glucose levels

Benefits include:

a. Diabetes equipment
    i. Blood glucose monitors, including noninvasive glucose monitors and monitors for the blind
    ii. Insulin pumps and associated appurtenances may be covered under the DME benefit (8.7.2)
    iii. Insulin infusion devices
    iv. Podiatric appliances for the prevention and complications associated with diabetes
b. Diabetes supplies
    i. Test strips for blood glucose monitors
    ii. Visual reading and urine test strips
    iii. Lancets and lancet devices
    iv. Insulin and insulin analogs
    v. Injection aids
    vi. Syringes
    vii. Biohazard disposable containers
    viii. Prescriptive and nonprescriptive oral agents for controlling blood sugar levels
    ix. Glucagon emergency kits
c. Repairs and necessary maintenance of insulin pumps not otherwise provided for under the manufacturer's warranty or purchase agreement, rental fees for pumps during the repair and necessary maintenance of insulin pumps, neither of which shall exceed the purchase price of a similar replacement pump.
d. Diabetes self-management training, including nutrition counseling and counseling on the proper use of diabetes equipment and supplies
e. HbA1c lab test
f. Checking for kidney disease
g. Annual dilated eye exam or retinal imaging, including one performed by an optometrist or ophthalmologist

Insulin and diabetic supplies including insulin syringes, needles and lancets, test strips, glucometers and continuous glucose monitors are covered under the pharmacy benefit (section 8.8), when purchased from a pharmacy with a valid prescription and using a preferred manufacturer (see the preferred drug list on the Member Dashboard). Pumps may be covered under the DME benefit (section 8.7.2).

8.4.11 Diagnostic Procedures and Imaging

The Plan covers diagnostic services, including x-rays and laboratory tests, psychological and neuropsychological testing, and other diagnostic procedures related to treatment of a medical or mental health condition. Some of these procedures may need to be prior authorized.

All standard imaging procedures related to treatment of a medical condition are covered. Most advanced imaging services must be prior authorized (see section 7.1), including radiology (such as MR procedures like MRI and MRA, CT, PET and nuclear medicine) and cardiac imaging.

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

8.4.12 Foot Care (Routine)

Covered for the diagnosis and treatment of a specific current problem. Routine foot care is not covered unless otherwise required by the member's medical condition, such as diabetes, circulatory disorders of the lower extremities, peripheral vascular disease, peripheral neuropathy, or chronic arterial or venous insufficiency.

8.4.13 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 8.5.10):
    i. Breast/chest surgery
    ii. Gonadectomy (hysterectomy/oophorectomy or orchiectomy)
    iii. Reconstruction of the genitalia
    iv. Gender confirming facial surgery

8.4.14 Inborn Errors of Metabolism

Inborn errors of metabolism are related to a missing or abnormal gene at birth that affects the metabolism of proteins, carbohydrates and fats. The Plan covers treatment for inborn errors of metabolism for which standard methods of diagnosis, treatment and monitoring exist, including quantification of metabolites in blood, urine or spinal fluid, or enzyme or DNA confirmation in tissues. Coverage includes diagnosing, monitoring and controlling the disorders by nutritional and medical assessment, including but not limited to clinical visits, biochemical analysis and medical foods used in the treatment of such disorders.

8.4.15 Infusion Therapy for Home Use

Home infusion therapy means the administration of fluids, nutrition, or medication (including all additives and chemotherapy) by intravenous or gastrointestinal (enteral) infusion or by intravenous injection in the home setting. Home infusion therapy shall include:

a. Drugs and IV solutions;

b. Pharmacy compounding and dispensing services;
c. All equipment and ancillary supplies necessitated by the defined therapy;
d. Delivery services;
e. Patient and family education; and
f. Nursing services.

Over-the-counter products which do not require a professional provider's prescription, including but not limited to standard nutritional formulations used for enteral nutrition therapy, are not included within this benefit.

For some medications, authorization may be limited to preferred medication suppliers only.

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

8.4.16 Kidney Dialysis

Covered expenses include:

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

Members with end-stage renal disease (ESRD) will receive the best benefit if they are enrolled in Medicare Part B.

8.4.17 Medication Administered by Provider, Home Infusion or Treatment Center

Medications that must be given in a professional provider's office, treatment center or home infusion are generally covered at the same benefit level as supplies and appliances (see Section 4).

Some medications may not be covered unless they are purchased from a preferred medication supplier. In this case, the medication is covered under the pharmacy specialty medication benefit.

For some medications, members must 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 7.1).

See section 8.4.15 for more information about home infusion therapy and prior authorization requirements. Self-administered medications are not covered under this benefit (see section 8.8.7). See section 8.8 for pharmacy benefits.

8.4.18 Mental Health

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

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

Intensive outpatient treatment and TMS require prior authorization. See section 8.4.11 for coverage of diagnostic services.

Quantitative or non-quantitative limitations applied to mental health services will not be more restrictive than limitations imposed on coverage of benefits for medical or surgical expenses.

8.4.19 Nutritional Therapy

Dietary or nutritional therapy is covered for certain conditions (excluding obesity). Nutritional therapy for eating disorders requires authorization after the first 5 visits. Preventive nutritional therapy that may be required under the Affordable Care Act is covered under the preventive care benefit. Also see diabetes care (section 8.4.10) and inborn errors of metabolism (section 8.4.14).

An inpatient nutritional assessment program is covered when provided in a hospital and approved by Moda Health.

8.4.20 Office or Home Visits

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

8.4.21 Rehabilitation & Habilitation

Rehabilitative and habilitative services are physical, occupational or speech therapies provided by a licensed physical, occupational or speech therapist, physician, chiropractor or other professional provider licensed to provide such services.

Rehabilitative or habilitative services are subject to an annual limit. A session is one visit. No more than one session of each type of physical, occupational or speech therapy is covered in one day. Limits apply separately to rehabilitative and habilitative services. Medically necessary outpatient services for mental health and chemical dependency are not subject to these limits. Rehabilitative and habilitative services related to hearing aids and cochlear implants are covered if deemed necessary for educational gain.

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.

For children under age 3 with developmental delay, rehabilitative and habilitative therapies are covered in accordance to an individualized family service plan issued by the Interagency Council on Early Childhood Intervention. Rehabilitative and habilitative therapies include evaluations and services for occupational therapy, physical therapy, speech therapy, and dietary or nutritional evaluations.

8.4.22 Surgery

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

Certain surgical procedures are covered only when performed as outpatient surgery. Members should ask their professional provider if this applies to a proposed surgery or contact Customer Service. See sections 8.5.11 and 8.5.12 for more information about cosmetic and reconstructive surgery.

Oral surgery for reduction of a dislocation, excision of, and injection of the temporomandibular joint is covered, except as excluded under the Plan (see Section 9).

8.4.23 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 sections 8.4.17 and 8.8.7.

8.4.24 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

8.5 INPATIENT & RESIDENTIAL FACILITY CARE

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

Facilities operated by agencies of the federal government are not considered hospitals. However, the Plan will cover expenses incurred in facilities operated by the federal government where benefit payment is required by law. Any covered service provided at any hospital owned or operated by the state of Texas is also eligible for benefits.

8.5.1 Chemical Dependency Detoxification Program

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

8.5.2 Diagnostic Procedures

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

8.5.3 Hospital Services

The Plan covers medically necessary services for hospital care including:

a. **Hospital room.** The actual daily charge

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

8.5.4 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.

8.5.5 Medication Administered at a Preferred Treatment Center

For some medications, members must 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 7.1).

8.5.6 Pre-admission Testing

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

8.5.7 Rehabilitative & Habilitative Care

To be a covered expense, rehabilitative services must be a medically necessary part of a physician's formal written program to improve and restore lost function following illness or injury.

8.5.8 Residential Mental Health &Chemical Dependency Treatment Programs

Room and treatment services by a treatment program that meets the definitions in the Plan (see Section 3) are covered.

Medically necessary services for mental health care or serious mental illness in a psychiatric day treatment facility, a crisis stabilization unit or facility, or a residential treatment center for children and adolescents in lieu of hospitalization will be covered under the inpatient hospital expense.

8.5.9 Skilled Nursing Facility Care

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

Covered services and supplies for skilled nursing facility care include:

a. All usual nursing care by a Registered Nurse (R.N.), Advanced Practice Nurse (A/P.N.), or by a Licensed Vocational Nurse (L.V.N.)
b. Room and board and all routine services, supplies, and equipment provided by the skilled nursing facility
c. Physical, occupational, speech, and respiratory therapy services by licensed therapists

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

Exclusions
The following skilled nursing facility charges are not covered:

a. If the member was admitted before they were covered by this policy
b. if the care is mainly for:
    i. Cognitive decline
    ii. Dementia, including Alzheimer's disease

Expenses for non-medical self-help or training, personal hygiene or custodial care are not covered.

8.5.10 Surgery

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

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

8.5.11 Surgery, Cosmetic& Reconstructive

The following expenses for cosmetic and reconstructive surgery will be covered:

a. Treatment provided for the correction of defects incurred in an accidental injury sustained by a member
b. Treatment provided for reconstructive surgery following cancer surgery
c. Surgery performed for the treatment or correction of a congenital defect or craniofacial abnormality
d. Reconstruction of the breast on which mastectomy has been performed (see section 8.5.12)

Surgery for breast augmentation, achieving breast symmetry, and replacing breast implants (prosthetics) to accomplish an alteration in breast contour or size are not covered, except as provided in section 8.5.12.

8.5.12 Surgery, Reconstructive Following a Mastectomy

The Plan covers reconstructive surgery following a medically necessary mastectomy:

a. All stages of reconstruction of the breast on which the mastectomy has been performed, including nipple reconstruction, skin grafts and stippling of the nipple and areola
b. Surgery and reconstruction of the other breast to produce a symmetrical appearance
c. Prostheses

d. Treatment of physical complications, including lymphedemas, at all stages of the mastectomy.
e. Inpatient care for a minimum of 48 hours following a mastectomy and 24 hours following a lymph node dissection for the treatment of breast cancer, unless the attending physician determines that a shorter period of inpatient care is appropriate.

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

8.5.13 Transplants

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

Definitions

Authorized transplant facility is a healthcare facility with which Moda Health has contracted and arranged to provide transplant services.

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

Transplant means a procedure or a series of procedures by which:

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

Corneal transplants and the collection and/or transfusion of blood or blood products are not considered transplants for the purposes of this section and are not subject to this section's requirements.

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

Covered Benefits. Benefits for transplants are limited as follows:

a. Transplant procedures must be performed at an authorized transplant facility.
b. Services and supplies related to an organ or tissue including, but not limited to, x-rays, laboratory testing, chemotherapy, radiation therapy, prescription drugs, procurement of organs or tissues from a living or deceased donor, and complications arising from the transplant.
c. Donor costs are covered as follows:
    i. If the recipient is enrolled in this policy, donor costs related to a covered transplant, including expenses for an enrolled donor resulting from complications and unforeseen effects of the donation, 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.

d. Professional provider transplant services are paid according to the 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 8.8).
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.
g. An FDA-approved artificial device implanted in the body is covered.
h. Coverage of each type of solid organ transplant is limited to one initial transplant and one subsequent re-transplant due to rejection.

8.6 MATERNITY CARE

Pregnancy care, childbirth and related conditions are covered when rendered by a professional provider. Professional providers do not include midwives unless they are licensed and certified.

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. See section 8.4.10 for gestational diabetes benefits.

Home birth expenses are not covered other than the fees billed by a professional provider. Additional information regarding home birth exclusions is in Section 9. 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.

8.6.1 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 equipment. Charges for supplies such as milk storage bags and extra ice packs, bottles or coolers are not covered. Hospital grade pumps are covered when medically necessary.

8.6.2 Complications of Pregnancy

Covered expenses are paid the same as other illness and are limited to services and supplies medically necessary for treating involuntary complications of pregnancy including:

a. Conditions (when pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by or caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion hyperemesis gravidarum, preeclampsia, and similar medical and surgical conditions of comparable severity
b. Non-elective Cesarean section, ectopic pregnancy which is terminated and spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible

Complications of pregnancy does not include false labor, occasional spotting, provider-prescribed rest during the period of pregnancy, morning sickness, elective Cesarean section, and similar

conditions associated with the management of a difficult pregnancy but not constituting a nosologically distinct complication of pregnancy.

8.6.3 Circumcision

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

8.6.4 Diagnostic Procedures

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

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

8.6.5 Newborn Screening Tests

The Plan covers screening for certain genetic disorders as required by the Texas Department of State Health Services, including the cost of a test kit up to the amount published by the Department.

8.6.6 Office, Home or Hospital Visits

A visit means the member is actually examined by a professional provider such as pregnancy care and childbirth visits.

8.6.7 Hospital Benefits

Covered hospital maternity care expenses consist of the following:

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

8.6.8 Special Right Upon Childbirth (Newborns' and Mothers' Health Protection Act)

Benefits for any hospital length of stay in connection with childbirth:

a. Will not be restricted to less than 48 hours following an uncomplicated vaginal delivery or 96 hours following an uncomplicated cesarean section unless the mother's or newborn's attending professional provider, after consulting with the mother, chooses to discharge the mother or her newborn earlier. Prior authorization is not required for a length of stay up to these limits.
b. If a covered mother or the newborn child is discharged before the 48 or 96 hours has expired, the Plan will provide coverage for postdelivery care.
c. Postdelivery care includes parent education, and the performance of any necessary and appropriate clinical tests. Care will be provided by a physician, registered nurse or other

appropriate licensed provider, and the mother will have the option of receiving the care at her home, the health care provider's office or a health care facility.

8.7 OTHER SERVICES

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

8.7.1 Acquired Brain Injury

Covered expenses for testing and treatment necessary as a result of or related to an acquired brain injury, including:

a. Cognitive rehabilitation therapy: Services designed to address therapeutic cognitive activities, based on an assessment and understanding of the individual's brain-behavioral deficits.
b. Cognitive communication therapy: Services designed to address modalities of comprehension and expression, including understanding, reading, writing, and verbal expression of information.
c. Neurocognitive therapy: Services designed to address neurological deficits in informational processing and to facilitate the development of higher level cognitive abilities.
d. Neurocognitive rehabilitation: Services designed to assist cognitively impaired individuals to compensate for deficits in cognitive functioning by rebuilding cognitive skills and/or developing compensatory strategies and techniques.
e. Neurobehavioral testing: An evaluation of the history of neurological and psychiatric difficulty, current symptoms, current mental status, and premorbid history, including the identification of problematic behavior and the relationship between behavior and the variables that control behavior. This may include interviews of the individual, family, or others.
f. Neurobehavioral treatment: interventions that focus on behavior and the variables that control behavior
g. Neurophysiological testing: An evaluation of the functions of the nervous system
h. Neurophysiological treatment: Interventions that focus on the functions of the nervous system
i. Neuropsychological testing: The administering of a comprehensive battery of tests to evaluate neurocognitive, behavioral, and emotional strengths and weaknesses and their relationship to normal and abnormal central nervous system functioning.
j. Neuropsychological treatment: Interventions designed to improve or minimize deficits in behavioral and cognitive processes.
k. Psychophysiological testing: An evaluation of the interrelationships between the nervous system and other bodily organs and behavior.
l. Psychophysiological treatment: Interventions designed to alleviate or decrease abnormal physiological responses of the nervous system due to behavioral or emotional factors.
m. Neurofeedback therapy: Services that utilize operant conditioning learning procedures based on electroencephalography (EEG) parameters, and are designed to result in improved mental performance and behavior, and stabilized mood.
n. Remediation: The process or processes of restoring or improving a specific function.
o. Post-acute transition services: Services that facilitate the continuum of care beyond the initial neurological insult through rehabilitation and community reintegration.

p. Post-acute-care treatment services: Services provided after acute-care confinement and/or treatment that are based on an assessment of the individual's physical, behavioral, or cognitive functional deficits, which include a treatment goal of achieving functional changes by reinforcing, strengthening, or reestablishing previously learned patterns of behavior and/or establishing new patterns of cognitive activity or compensatory mechanisms.
q. Outpatient day treatment services: Structured services provided to address deficits in physiological, behavioral, and/or cognitive functions. Such services may be delivered in settings that include transitional residential, community integration, or nonresidential treatment settings.
r. Community reintegration services: Services that facilitate the continuum of care as an affected individual transitions into the community.

The policy includes coverage for expenses related to periodic reevaluation of the care of a member who:

a. Has incurred an acquired brain injury
b. Has been unresponsive for treatment; and
c. Becomes responsive to treatment at a later date.

Treatment goals for services may include the maintenance of functioning or the prevention of or slowing of further deterioration.

8.7.2 Durable Medical Equipment (DME), Supplies & Appliances

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

Some examples of DME, supplies and appliances are:

a. CPAP for sleep apnea
b. Glasses or contact lenses for the diagnoses of aphakia or keratoconus
c. Insulin pumps
d. Hospital beds and accessories
e. Intraocular lenses within 90 days of cataract surgery
f. Light boxes or light wands only when treatment is not available at a provider’s office
g. Oxygen and oxygen supplies
h. Prosthetic and Orthotic devices.
i. Wheelchair or scooter (including maintenance expenses)

Benefits include:

a. Devices that are medically necessary to restore or maintain the ability to complete activities of daily living or essential job-related activities
b. Devices that are not only for comfort or convenience
c. Repair or replacement
d. Supplies medically necessary for the effective use of a prosthetic or orthotic device
e. Costs for making its design, fabrication, material and component selection, measurements, fittings, static and dynamic alignments
f. Charges for instructing the patient in the use of the device

g. The most appropriate model that adequately meets the member's medical needs as determined by the treating provider

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 8.8 for coverage under the Pharmacy benefit).

The Plan covers the rental charge for DME unless purchase of the equipment is required by Moda Health. For most DME, the rental charge is covered up to the purchase price. Members can work with their providers to order their prescribed DME.

Moda Health encourages the use of a preferred DME provider. Using a preferred DME provider may help members save money. Find a preferred provider using Find Care in the Member Dashboard (see section 6.2.2). A member can change a recurring prescription or automated billing to a preferred DME provider by contacting the member's 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 7). Replacement or repair is only covered if the appliance, prosthetic, equipment or DME was not abused, was not used beyond its specifications and not used in a manner to void applicable warranties. Upon request, members must authorize any supplier furnishing DME to provide information related to the equipment order and any other records Moda Health requires to approve a claim payment.

Exclusions
In addition to the exclusions listed in Section 9, the Plan will not cover the following appliances and equipment, even if they relate to a condition that is otherwise covered:

a. Those used primarily for comfort, convenience or cosmetic purposes
b. Those used for education or environmental control (examples of Supportive Environmental materials can be found in Section 9)
c. Therapeutic devices, except for transcutaneous nerve stimulators
d. Dental appliances and braces
e. Incontinence supplies
f. Supporting devices such as corsets, compression or therapeutic stockings except when such stockings are medically necessary
g. Testicular prostheses

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

8.7.3 Home Health Care

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

The home health care benefit consists of medically necessary intermittent home health care visits. Home health care 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 Nurse (R.N.), Advanced Practice Nurse (A.P.N.) or by a Licensed Vocational Nurse (L.V.N.)
b. Home health aide providing part-time or intermittent services which consist primarily of care for the patient
c. Physical, occupational, speech or respiratory therapist

The home health care benefit does not include:

a. Food or home delivered meals
b. Social case work or homemaker services
c. Services provided primarily for custodial care
d. Transportation services
e. Home Infusion Therapy
f. Durable medical equipment
g. Home health care, home care services, equipment and supplies provided as part of a hospice treatment plan. These are covered under sections 8.7.4 and 8.7.2.

The following are considered as one visit for home health services:

a. A visit by a representative of a home health agency
b. 4 hours of home health aide service
c. If home health aide service extends beyond 4 hours, each additional 4 hours or portion of that 4-hour period

8.7.4 Hospice Care

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

Definitions

Hospice means a facility or agency primarily engaged in providing skilled nursing care and other therapeutic care for terminally ill patients and which is:

a. Licensed in accordance with state law (where the state law provides for such licensing); or
b. Certified by Medicare as a supplier of hospice care.

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

Hospice Home Care

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

a. Part-time or intermittent nursing care by a Registered Nurse (R.N.), Advanced Practice Nurse (A.P.N.), or by a Licensed Vocational Nurse (L.V.N.)
b. Home health aide providing part-time or intermittent services which consist primarily of caring for the patient
c. Licensed therapists providing physical, speech, and respiratory services
d. Hospice agency providing homemaker and counseling services, including bereavement counseling

Hospice Inpatient Care
Covered services and supplies include:

a. Room and board, and routine services, supplies and equipment provided by the hospice facility
b. Physical, speech, and respiratory therapy services provided by licensed therapists

8.7.5 Telemedicine, Teledentistry dental services and Telehealth (Virtual Care Visits)

Telehealth, telemedicine services and teledentistry dental services (also known as virtual care visits), when generally accepted healthcare practices and standards of care determine they can be safely and effectively provided using telecommunication or information technology, are covered to the extent covered services are covered in an in-person setting. Virtual care visits through CirrusMD at cirrusmd.com/modahealth are covered at no cost sharing. Members may call Customer Service for more information.

Unless provided by CirrusMD, telehealth, telemedicine services and teledentistry dental services do not include services provided by only synchronous or asynchronous audio interaction, including:

a. an audio-only telephone consultation
b. a text-only e-mail message
c. a facsimile transmission

8.7.6 Payment to the Texas Department of Human Services

All benefits paid on behalf of children must be paid to the Texas Department of Human Services whenever:

a. the Texas Department of Human Services is paying benefits under the Human Resources Code, Chapter 31 or Chapter 32
b. the parent who is insured under the policy has possession or access to the child as a result of a court order, or is not entitled to access or possession of the child and is required by the court to pay child support

All covered expenses paid on behalf of the member must be paid to the Texas Department of Human Services for the actual cost of medical expenses the department pays through medical assistance.

8.8 PHARMACY PRESCRIPTION BENEFIT

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

At the point of sale, members are not required to pay more than the applicable copay or coinsurance, the maximum plan allowance or the amount members would have to pay without health insurance or other medication benefits or discounts, whichever is lesser.

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.

8.8.1 Definitions

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

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

Formulary is a listing of all prescription medications and their coverage under the pharmacy prescription benefit. This listing is reviewed and updated at a regular interval to ensure clinical considerations, as well as quality and cost are appropriately considered. Members will receive a 60-day advance notice before modifications to the formulary are made. Modifications to the formulary only occur at renewal. A prescription price check tool is available on the Member Dashboard under the pharmacy tab. This online formulary tool provides coverage information, treatment options and price estimates, see section 2.1.

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

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

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

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

Prescription Medication List means the Moda Health Prescription Medication List. The list is available on modahealth.com. It provides information about the coverage of commonly prescribed medications. It is not an all-inclusive list of covered products. Medications that are

new to the market are subject to review and may have additional coverage limitations established by Moda Health.

The prescription medication list and the tiering of medications may change and will be periodically updated. A prescription price check tool is available on the Member Dashboard under the pharmacy tab. Members with any questions regarding coverage should contact Customer Service. Moda Health will respond to a member's request whether a medication is on the formulary no later than the third business day after the request.

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

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

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

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

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

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

8.8.2 Covered Expenses

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

a. It is for a covered medication supply that is prescribed for a member, or
b. Is for an OTC contraceptive the member has bought
c. It is incurred while the member is eligible under the policy
d. The prescribed medication is not excluded

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

a. Is for the purpose of preventing, evaluating, diagnosing or treating a medical condition or its symptoms

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

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

8.8.3 Covered Medication Supply

Includes the following:

a. A prescription medication that is medically necessary for treatment of a chronic disabling, or life-threatening illness covered by the Plan if the medication has been approved by the United States Food and Drug Administration for at least one indication and is recognized by the following for treatment of the indication for which the medication is prescribed:
    i. A standard reference compendium; or
    ii. Substantially accepted peer-reviewed medical literature
    iii. Coverage of a medication under this requirement must include coverage of medically necessary services associated with the administration of the medication
b. Compounded medications containing at least one covered medication as the main ingredient
c. Insulin and diabetic supplies including insulin syringes, needles and lancets, test strips, glucometers and continuous glucose monitors. Must have a valid prescription and use a preferred manufacturer
d. An emergency refill of insulin up to a 30-day supply or insulin-related equipment (including needles, syringes, cartridge systems, prefilled pen systems, glucose meters, continuous glucose monitor supplies, and test strips, but excluding insulin pumps) not to exceed the lesser of a 30-day supply or the smallest available package if the emergency refill criteria as required by law are met by the pharmacist. The emergency refill is covered at the same benefit level as a nonemergency refill
e. Certain prescribed preventive medications required under the Affordable Care Act
f. Medications for treating tobacco dependence, including OTC nicotine patches, gum or lozenges, with a valid prescription and from an in-network retail pharmacy are covered with no cost sharing as required under the Affordable Care Act
g. Prescription contraceptive medications and devices for birth control (section 8.3.4) and medical conditions covered under the policy. Each contraceptive can be filled by the

pharmacy up to a 3-month supply for the member's first use of the medication and up to 12-month supply for subsequent fills. Contact Customer Service for information on how to obtain a 12-month supply.

h. Certain immunizations and related administration fees are covered with no cost sharing at in-network retail pharmacies (e.g. flu, pneumonia and shingles vaccines)
i. Refills of prescription eye drops treating a chronic eye disease are covered as required by law.
j. Dietary formulas necessary for the treatment of phenylketonuria (PKU) or other heritable disease.
k. Amino acid-based elemental formulas, regardless of the formula delivery method, used for the diagnosis and treatment of:
    i. Immunoglobulin E and non-immunoglobulin E mediated allergies to multiple food proteins;
    ii. Severe food protein-induced enterocolitis syndromes;
    iii. Eosinophilic disorders, as evidenced by the results of biopsy; and
    iv. Disorders affecting the absorptive surface, functional length, and motility of the gastrointestinal tract

Certain prescription medications and/or quantities of prescription medications may require prior authorization (see section 7.1). Some medications used to treat complex chronic health conditions must be dispensed through a Moda-designated specialty pharmacy provider.

For assistance coordinating prescription refills, contact Pharmacy Customer Service. Emergency insulin refills and supplies are limited to the lesser of the smallest available package or a 30-day supply and are covered no more than 3 times per year.

The member or professional provider can request a medication that is not on the formulary through the Member Dashboard 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 or preferred medications would reasonably be expected to cause harm or not produce equivalent results as the requested medication
d. The requested medication therapy is evidence-based and generally accepted medical practice

Moda Health 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, step therapy or plan limitations and exclusions.

8.8.4 Mail Order Pharmacy

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

8.8.5 Specialty Services & Pharmacy

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

Most specialty medications must be prior authorized. If a member does not purchase specialty medications at the Moda-designated specialty pharmacy, the expense will not be covered. Some specialty prescriptions may have shorter day supply coverage limits. Some medications may be eligible for a 90-day supply. For some specialty medications, members may be required to enroll in programs to ensure proper medication use and/or reduce the cost of the medication. More information is available on the Member Dashboard or by contacting Customer Service.

8.8.6 Medication Synchronization Plan

Members who are filling more than one prescribed medication on an ongoing basis may have the option to coordinate the refilling of the medications to a single pharmacy visit. To take advantage of this option, members should notify their pharmacist that the plan allows medication synchronization. If a medication is approved for synchronization, Moda Health will prorate a member's cost sharing amount charged for a partial supply and cover the medication during the period set in the synchronization plan. If appropriate, Moda Health will also work with the pharmacy or pharmacist to override denial of coverage in accordance to the synchronization plan.

The following criteria must be met:

a. The medication must be covered by the policy
b. The medication is for treating a chronic illness that may be reasonably expected to continue for an uninterrupted period of at least 3 months and controlled but not cured by medical treatment
c. The medication may be prescribed with refills
d. The medication is a formulation that can be effectively dispensed in accordance with the medication synchronization plan
e. The medication is not a Schedule II controlled substance or a Schedule III controlled substance containing hydrocodone according to the Health and Safety Code

8.8.7 Self-Administered Medication

All self-administered medications are subject to the prescription medication requirements of section 8.8. Self-administered specialty medications are subject to the same requirements as other specialty medications (section 8.8.5).

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

8.8.8 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.

Step therapy requirements do not apply to medications approved by the United States Food and Drug Administration that are associated with the treatment of stage-four advanced, metastatic cancer and associated conditions.

A prescribing provider may submit, on behalf of a member, a written request for an exception to the step therapy protocol. If Moda Health does not deny an exception request within the 72 hours after the request is received, the request is considered approved. However, if the exception request indicates that the prescribing provider reasonably believe that denial of the request makes the death or serious harm to the patient probable, the request is considered granted if Moda Health does not deny the request within 24 hours after we receive the request.

The denial of an exception request under this section is considered an adverse benefit determination and is subject to appeal and external review rights (see section 11.2.5).

8.8.9 Limitations

The following limitations apply:

a. New FDA approved medications are subject to review and may have additional coverage requirements or limits set by the Plan. A member or prescriber can request a medical necessity evaluation if a newly approved medication is initially denied during the review period
b. If a brand medication is filled by the pharmacy when a generic equivalent is available, the member may have to pay the difference in cost between the generic and brand medication. Expenses incurred due to brand substitution do not count toward the out-of-pocket maximum.
c. Certain brand medications may be prior authorized for a specific amount of time or until a generic medication becomes available, whichever comes first. When a generic medication becomes available during the authorized period, the brand 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 the use of 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 durations of use may be limited to a 15-day supply
f. Medications with dosing intervals greater than the Plan's maximum day supply will have an increased copayment to match the day supply.
g. Medications purchased outside of the United States and its territories are only covered in emergency and urgent care situations
h. Early refill of medications for travel outside of the United States will be reviewed. When allowed, early refill is limited to once every 6 months. Early refill cannot be used to cover a medication supply beyond the end of the plan year.

8.8.10 Exclusions

In addition to the exclusions listed in Section 9, the following medication supplies are not covered:

a. **Devices.** Including but not limited to therapeutic devices and appliances. Information for contraceptive devices is in section 8.8.3 and for other devices in section 8.7.2

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 he or she is a patient in a hospital, rest home, skilled nursing facility, extended care facility, nursing home or similar institution
f. **Medication Administration.** A charge for administration or injection of a medication, except for certain immunizations or contraceptives at in-network pharmacies
g. **Medications Covered Under Another Benefit.** Such as medications covered under 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, except as permitted under section 8.8.3.
l. **Over the Counter (OTC) Medications** and certain prescription medications for which there is an OTC equivalent or alternative, except for contraceptives or those treating tobacco dependence
m. **Repackaged Medications**
n. **Replacement Medications and/or Supplies**
o. **Vitamins and Minerals.** Except as required by law
p. **Weight Loss Medications**

8.9 VISION CARE BENEFIT

8.9.1 Pediatric Vision Services

The policy 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 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. Hi-index lenses

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

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

In addition to the exclusions listed in Section 9, the following services and supplies are not covered:

a. Plan lenses with refractive correction of less than ± 50 diopter
b. Two pairs of glasses instead of bifocals
c. Insurance policies or service 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

8.9.2 Adult Vision Services

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

Members can visit www.vsp.com or call 800-877-7195 to choose a vision care provider and arrange for a vision exam. For members who are eligible for a vision exam, VSP will provide benefit authorization directly to the provider. Should members receive services from an in-network vision care provider without such benefit authorization they are responsible for payment in full to the provider and will need to submit a request for reimbursement by completing the member reimbursement claim form, which is available by visiting www.vsp.com or calling 800-877-7195. If members receive services from a provider who is not in the VSP network, the services will not be covered.

8.10 HEARING SERVICES

Hearing exams, hearing aid checks and aided testing are covered once per year. Treatment related to hearing aids, including coverage for habilitation and rehabilitation as necessary for educational gain, is covered.

The following items are covered once every 3 years:

a. One hearing aid per hearing impaired ear including fitting and dispensing services
b. Repairs, servicing or alteration of the hearing aid equipment
c. One year supply of batteries for each hearing aid
d. Ear molds

The hearing aid must be prescribed, fitted and dispensed by a licensed audiologist or hearing aid specialist with the approval of a licensed physician.

To get the highest benefit level for the above hearing services, members can call Hearing Services Customer Service to choose an in-network audiologist and arrange for a hearing exam. The audiologist will assist members with choices of hearing aids available to Plan members by the hearing services vendor through an in-network hearing instrument provider. Members can also use other in-network providers.

In addition to the exclusions listed in Section 9, 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. Additional batteries, hearing aid accessories 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

8.11 NONINSURANCE BENEFITS

Members are provided with additional benefits and services. These additional services are a complement to the policy but are not insurance. Members may call Customer Service if they have trouble getting services from these vendors. Moda Health will either work with the vendors or make other arrangements to provide the services.

These benefits and services will end when this policy ends. Moda Health may also discontinue some of these benefits and services for all subscribers. Before any discontinuation, Moda Health will send a notice 30 days in advance to inform members.

a. Discounted gym membership through Active&Fit Direct, including:
    i. Access to fitness studios and fitness centers nationwide
    ii. The option to change membership to a different fitness studio or fitness center at any time
    iii. Access to digital workout videos and a library of digital resources
    iv. Activity tracking from a variety of wearable fitness devices and apps

    Access to the discounted gym membership is automatically available to members when they enroll in this policy. Members do not have to accept or decline this discount.

b. Wellness services and discounts through ChooseHealthy, including:
    i. Discounts on popular health and fitness brands
    ii. Savings on services from specialty health practitioners including acupuncture, chiropractic, and therapeutic massage
    iii. Access to no-cost online health classes

    The wellness services and discounts are automatically available to members when they enroll in this policy and there is no additional cost for members to use these services. Members do not have to accept or decline these services.

c. Travel assistance services through Assist America, including, but not limited to:
    i. Medical consultation, evaluation and referral
    ii. Foreign hospital admission assistance
    iii. Emergency medical evacuation
    iv. Arrangements for the member to be transported home or to a rehabilitation facility upon being discharged from the hospital
    v. Care of minor children left unattended as a result of a medical emergency

    Travel assistance services are automatically available when members enroll in this policy. Members do not have to accept or decline the services. There is no additional cost for members to use the services.

d. Individual Assistance Program (IAP), a free and confidential service through Canopy assisting members with a variety of personal concerns, including:
    i. Marital concerns
    ii. Conflict at work
    iii. Depression or anxiety
    iv. Stress management
    v. Family relationships
    vi. Financial, legal and consumer concerns
    vii. Alcohol or drug abuse

    IAP counselors can help members identify problems, establish goals, make recommendations and develop an action plan.

    The IAP is automatically available when members enroll in this policy. Members do not have to accept or decline the services. There is no additional cost for members to use the services.

e. Comprehensive diabetes management program through Livongo, including:
    i. A smart meter that uploads blood glucose readings
    ii. Strips and lancets shipped directly to members
    iii. Coaches available via phone, text or mobile app for guidance on nutrition and lifestyle questions

    The diabetes management program through Livongo is automatically available when members enroll in this policy. Members do not have to accept or decline the services. There is no additional cost for members to use the services.

f. Fitbit personalized wellness program, including
    i. Discounts on select Fitbit devices
    ii. 1:1 personalized support from a certified health coach
    iii. Access to thousands of workouts
    iv. Fitness challenges
    v. Guided, customizable health programs
    vi. Personalized information to improve health
    vii. Advanced sleep tools

Access to the Fitbit program is automatically available when members enroll in this policy. Members do not have to accept or decline the services. There is no additional cost for members to use the services.

8.12 WELLNESS BENEFITS

The benefits below are available to members being prescribed specific medications for diabetes and cardiovascular conditions and are offered to encourage members to timely refill their prescriptions.

Members can receive cost sharing discounts on the qualifying medications through Sempre Health, when they refill their medications as prescribed. Members will also receive alerts when it is time to refill prescriptions and qualify to receive increased cost sharing discounts when they refill their prescriptions on time.

Access to the discounts available through Sempre Health are automatically available when members enroll in this policy. Members will receive an enrollment invitation if they are being prescribed qualifying medications. There is no additional cost for members to use the services.

These services will end when the policy ends. Moda Health may also discontinue these services for all policyholders. Before Moda Health discontinues these services, members will be sent a notice 30 days in advance.

SECTION 9. 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 Plan, or if recommended, referred or provided by an in-network provider. Any direct complication or consequence that arises from these exclusions will not be covered, except for emergency medical conditions.

Abortion
Except in the case of rape, incest or when the life of the mother is endangered

Acupuncture

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

Care Outside the United States
Scheduled care or care that is not for emergency care

Charges Over the Maximum Plan Allowance
Except when balance billing is prohibited by federal or state law

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

Contraception
Any men's contraceptive that can be legally dispensed without a prescription

Cosmetic Procedures
Any procedure or medication requested for the purpose of improving or changing appearance without restoring impaired body function, including rhinoplasty, breast augmentation, lipectomy, liposuction and hair removal (including electrolysis and laser). Exceptions are provided for reconstructive surgery if medically necessary and not specifically excluded (see sections 8.4.13, 8.5.11 and 8.5.12).

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

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

Dental Examinations and Treatment; Orthodontia
Except as specifically provided for in sections 8.4.8

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

Enrichment Programs
Psychological or lifestyle enrichment programs including educational programs, assertiveness training, marathon group therapy, and sensitivity training unless provided as a medically necessary treatment for a covered medical condition

Experimental or Investigational Procedures
Including expenses incidental to or incurred as a direct consequence of such procedures (see definition of experimental/investigational in Section 3). Except as otherwise provided for in section 8.4.6.

Faith Healing

Financial Counseling Services

Food Services
Meals on Wheels and similar programs

Guest Meals in a Hospital or Skilled Nursing Facility

Hearing Aids
Except as specifically provided for in section 8.10

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

Homemaker or Housekeeping Services

Homeopathic Treatment and Supplies

Illegal Acts
Services and supplies for treatment of a medical condition caused by or arising directly from a member's illegal act or occupation. 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 and treatment of infertility, as well as the cause of infertility. Includes surgery to reverse elective sterilization (vasectomy or tubal ligation) and charges for surrogate parenting.

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

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

Legal Counseling

Massage or Massage Therapy

Mental Examination and Psychological Testing and Evaluations
For the purpose of adjudication of legal rights, administrative awards or benefits, corrections or social service placement, employment, or any use except as a diagnostic tool for the treatment of a mental health condition.

Missed Appointments

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

Necessities of Living
Including but not limited to food, clothing and household supplies. Related exclusion is under Supportive Environmental Materials

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

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

Nutritional Counseling
Except as provided for in section 8.4.19

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

a. Gastric restrictive procedures with or without gastric bypass, or the revision of such procedures

b. Weight management services such as weight loss programs, exercise programs, counseling, hypnosis, biofeedback, neurolinguistic programming, guided imagery, relaxation training and subliminal suggestion used to modify eating behaviors
c. Any medication or formula related to or resulting from the treatment of weight loss or obesity even if prescribed by a physician

The Plan covers services and supplies that are necessary for the treatment of established medical conditions that may be caused by or made worse by obesity, but services and supplies that do so by treating the obesity directly are not covered, except as required under the Affordable Care Act.

Orthopedic Shoes
Except as provided in section 8.7.2

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

Out-of-Network Services
Except emergency services, and when out-of-network care has been prior authorized by Moda Health

Pastoral and Spiritual Counseling

Personality Disorders

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

Physical Exercise Programs

Private Nursing Services

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

Psychoanalysis or Psychotherapy
As part of an educational or training program, regardless of diagnosis or symptoms

Reports and Records
Including charges for the completion of claim forms or treatment plans

Routine Foot Care
Including the following services unless otherwise required by the member's medical condition, for example, diabetes, circulatory disorders of the lower extremities, peripheral vascular disease, peripheral neuropathy, or chronic arterial or venous insufficiency:

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

Self-Administered Medications
Including oral and self-injectable, when provided directly by a physician's office, facility or clinic instead of through the pharmacy prescription medication or anticancer benefits (sections 8.8.7 and 8.4.2)

Self Help Programs

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 Not Provided

Services Otherwise Available
Including those services or supplies when the member has no legal obligation to pay and:

a. for which payment could be obtained in whole or in part if a member had applied for payment under any city, county, state or federal law, except for Medicaid coverage
b. for which a member cannot be held liable because of an agreement between the provider and another third party payer that has paid or is obligated to pay for such service or supply
c. for which no charge is made (including reducing a charge due to a coupon or manufacturer discount), or for which no charge is normally made in the absence of insurance
d. a member could have received in a hospital or program operated by a government agency or authority. This exclusion does not apply to:
    i. covered services provided for treatment of mental illness or mental retardation provided by a tax supported institution of the state of Texas.
    ii. veterans of the armed forces, in which case covered services and supplies furnished by the Veterans' Administration of the United States and that are not service related are eligible for payment according to the terms of the Plan

Services Provided by a Family Member
Family member, for the purpose of this exclusion, include a member or a spouse or domestic partner, child, sibling or parent of a member or the member's spouse or domestic partner.

Services Provided by Volunteer Workers

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

Support Education
Including:
a. Level 0.5 education-only programs
b. Education-only, court mandated anger management classes

c. Family education or support groups, except as required under the Affordable Care Act

Supportive Environmental Materials
Including handrails, ramps, bath benches, humidifiers, air filters, air conditioners, heat lamps, tanning lights, whirlpools, hot tubs, and telephones, and other items that are not for the treatment of a medical condition even if they relate to a condition otherwise covered by the policy. Related exclusion is under Necessities of Living

Taxes

Telephone Visits and Consultations
Including telephone visits or consultations and telephone psychotherapy. This exclusion does not apply to covered case management services.

Telephones and Televisions in a Hospital or Skilled Nursing Facility

Temporomandibular Joint Syndrome (TMJ)
Any non-surgical or non-diagnostic services or supplies provided for the treatment of the temporomandibular joint and all adjacent or related muscles and nerves.

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

Transportation
Except medically necessary ambulance transport

Treatment in the Absence of Illness
Including individual or family counseling or treatment for marital, behavioral, family, occupational or religious problems, treatment for at risk individuals in the absence of illness or a diagnosed mental health or chemical dependence condition, or treatment of normal transitional response to stress

Treatment After Coverage Ends
Except for covered hearing aids ordered before coverage terminates and received within 90 days of the end date

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

Treatment Not Medically Necessary
Including services or supplies that are:

a. Not medically necessary for the treatment or diagnosis of a condition otherwise covered by the Plan or are prescribed for purposes other than treating disease
b. Inappropriate or inconsistent with the symptoms or diagnosis of 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 rendered for the convenience of a member or a provider
e. Not the least costly of the alternative supplies or levels of service that can be safely provided to a member

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

Vision Care
Except as otherwise provided in section 8.9. This includes any charges for orthoptics, vitamin therapy, low vision therapy, eye exercises or fundus photography. See section 8.4.10 for coverage of annual dilated eye exam for management of diabetes.

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

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

Wigs, Toupees, Hair Transplants

Work Related Conditions
Treatment of a medical condition arising out of or in the course of employment or self-employment for wages or profit, whether or not the expense is paid under any workers' compensation provision. This exclusion does not apply to owners, partners or executive officers if they are exempt from workers' compensation laws and no workers' compensation coverage is provided to them.

SECTION 10. ELIGIBILITY & ENROLLMENT

10.1 CHILD ONLY POLICY

If this is a child only plan, coverage is only available to age 26 and 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.

10.2 THE MARKETPLACE

Eligibility and enrollment are administered by the Marketplace. Contact the Marketplace for information. A subscriber may obtain coverage for newly acquired or newly eligible dependents by submitting an application 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 by Moda Health and processed for coverage to become effective.

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

10.3 SUBSCRIBER

To remain eligible for coverage, a person must satisfy the residency requirements of the Marketplace. To be a subscriber, a person must currently live in the service area and intend to live in the service area permanently or indefinitely. Members cannot be enrolled in Medicare. A person is not eligible to enroll if the main reason for living in the service area is to get health coverage or another temporary reason (such as getting treatment, living in a residential care facility to receive treatment, attending to a business matter or for personal pleasure) and they do not intend to reside in the service area indefinitely.

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

10.4 DEPENDENTS

A subscriber's legal spouse is eligible for coverage. A subscriber's children are eligible until their 26th birthday. Foster children are eligible only while legally a foster child.

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

a. The biological, adopted, or foster child of a subscriber or a subscriber's eligible spouse or domestic partner
b. Children placed for adoption with a subscriber or a subscriber's spouse or domestic partner. Adoption paperwork must be provided

c. Children whom a subscriber seeks to adopt, and the subscriber is a party to a lawsuit to adopt the child(ren)
d. Children for whom a subscriber must provide medical support due to a court order
e. Grandchildren who are dependents of the subscriber for federal income tax purposed at the time of application

A subscriber's child who has sustained a disability making the child physically or mentally incapable of self-support at even a sedentary level may be eligible for coverage even though the child is over 26 years old. To be eligible, the child must be unmarried and principally dependent on the subscriber for support and have had continuous medical coverage. The incapacity must have started, and the information below must be received, no later than 31 days after the child's 26th birthday. Social Security Disability status does not guarantee coverage under this provision. Moda Health will determine eligibility based on commonly accepted guidelines. To avoid a break in coverage, it is recommended that the following information be submitted to Moda Health no later than 31 days after the child's 26th birthday:

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

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

10.5 OPEN ENROLLMENT PERIODS

Persons can apply for coverage during the open enrollment period. For 2022, open enrollment is from November 1, 2021 to December 15, 2021. Open enrollment periods may be extended as prescribed by the Marketplace. These dates may be different in future years.

10.6 SPECIAL ENROLLMENT PERIODS

Persons can apply for coverage or enroll in another individual plan within 60 days of the following qualifying events:

a. Loss of minimum essential coverage due to loss of eligibility, but not as a result of nonpayment of premium, rescission, or voluntary termination of coverage (except at employer plan's non-calendar year open enrolment period)
b. Loss of coverage due to military discharge
c. Loss of coverage under Medicaid or a state child health plan
d. Obtaining new dependents through marriage, domestic partner registration, birth, adoption or placement for adoption or foster care
e. Child support order or other court order requiring coverage of a dependent
f. Becoming enrolled or disenrolled as a result of the error, misrepresentation or inaction of the Health Insurance Marketplace and its agents, or of the U.S. Department of Health and Human Services (HHS).

g. Having adequate evidence that there is a violation of a material provision made by the Qualified Health Plan (QHP) in which they are enrolled
h. Decertification of the QHP in which they are enrolled
i. Becoming newly ineligible for cost sharing reductions or advanced payments of the premium tax credit
j. Moving permanently to a new location with access to a new QHP
k. Gaining new access to an individual coverage HRA (ICHRA) or a qualified small employer HRA (QSEHRA)
l. Loss of coverage of a non-calendar year ICHRA or QSEHRA due to non-renewal at the end of the plan year
m. Becoming newly eligible for cost sharing reductions or advanced payments of the premium tax credit
n. Gaining law presence in the country such as citizenship
o. Release from incarceration

In the case of the loss of minimum essential coverage, permanent move to new area with different QHP options, or when a person covered on a group plan becomes newly eligible for advance payments of the premium tax credit due to being ineligible for qualifying coverage on the group plan, a person has 60 days before or after the event to enroll.

10.7 ELIGIBILITY AUDIT

Moda Health reserves the right to conduct audits to verify a member's eligibility, and may request documentation including but not limited to 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 Plan.

10.8 PREMIUMS

The current premium amount is shown on the premium notice. Members may contact the 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 Health must be notified in writing 15 days before the next deduction date. For other changes in billing option, Moda Health 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.

10.8.1 When Payments are Due

All premium payments are due on the first of the month. Except for the first premiums owed, if payment is not received within the grace period (section 10.8.2), this policy will end after an advance notice. If this policy ends because premiums have not been paid, Moda Health may require payment of any unpaid past-due premiums from the last 12 months before open enrollment or special enrollment coverage under a new Moda Health policy becomes effective.

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

10.8.2 Grace Period and Cancellation of Coverage

Subscribers will have a 10 day grace period for payment after the premium due date, during which grace period the policy shall continue in force. Subscribers 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.

Moda Health may cancel this policy at any time by written notice delivered to the subscriber, or mailed to the subscriber's last address on record with Moda Health, stating when the cancellation is effective, which may not be earlier than 5 days after the date the notice is delivered or mailed. After this policy has been continued beyond its original term, the subscriber may cancel the policy at any time by written notice delivered or mailed to Moda Health, effective on receipt or on a later date specified in the notice. In the event of cancellation, Moda Health will promptly return the unearned portion of any premium paid. If the subscriber cancels, the earned premium shall be computed by the use of the short-rate table last filed with the state of Texas where the subscriber resided when the policy was issued. If the subscriber cancels, the earned premium shall be computed pro rata. Cancellation is without prejudice to any claim originating before the effective date of cancellation.

10.8.3 Reinstatement

If this policy is terminated due to nonpayment of premium, Moda Health may agree to reinstate coverage under this policy upon the subscriber's request. 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. All premiums received as part of the reinstatement will be applied to the period of nonpayment of premium but not to any period more than 60 days prior to the date of reinstatement. Premium payments must be through electronic fund transfer (EFT) upon reinstatement.

10.8.4 Changes in Amount of Premiums

Premiums can change without notice when the family composition changes or the subscriber moves to a different rating area. The new premium 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. Thirty days written notice will be provided before a change in the premiums affecting all subscribers takes effect. When the new premium is paid, the payment will confirm the subscriber accepts the change.

10.9 WHEN COVERAGE ENDS

The circumstances in which a member's coverage will end are described below. Coverage will end at 11:59 p.m. on the last day of the month through which premiums are paid and on the last day of the grace period for nonpayment of premiums. When the subscriber's coverage ends, coverage for all enrolled dependents also ends.

a. The subscriber is no longer eligible for coverage through the Marketplace
b. The subscriber moves outside the Plan's service area

c. Loss of dependent eligibility, including dissolution of marriage or domestic partnership, or when a dependent child turns age 26, unless the dependent child has a disability and is incapable of self- support.
d. Non-payment of premium
e. Rescission for fraud or intentional material misrepresentation
f. Termination of the health benefit plan option
g. Moda Health's decertification to offer plans through the Marketplace
h. The subscriber ends the individual coverage after the required advanced notice or changes health benefit plan during an open enrollment or special enrollment period

Coverage may continue for members in the following situations:

a. If a member loses coverage due to the dissolution of marriage or domestic partnership, that member shall be issued a policy with the same coverage of the policy which was in effect prior to the dissolution of marriage or domestic partnership. The new policy will be issued without evidence of insurability and will have the same effective date as the policy under which coverage was afforded prior to the dissolution of marriage or domestic partnership.
b. in the event of a subscriber's death the spouse or domestic partner of the subscriber, if covered under the policy, shall become the subscriber.
c. If a member is determined to be pregnant at the time coverage is canceled by Moda Health, pregnancy benefits will be covered at the same level they would normally be covered if the policy continued in force.
d. If a member becomes totally disabled and the member's coverage under this plan ends, health expenses related to the injury or illness that caused the total disability may extend to cover specific situations for a period not to exceed 3 months. To be determined as totally disabled the member must not be able to be gainfully employed in a field for which either of they are specifically trained, unable to perform the regular duties of a job for which either of they are specifically trained, and not be able to perform the normal activities of a same gender healthy person within the member's same age range.

Moda Health will provide written notice for the following:

a. For a discontinuance and replacement, a 90-day notice to the subscriber prior to the discontinuance, with an explanation of the option to purchase any other individual plan, and that termination will be uniformly applied and not based on health status related factors of a covered individual
b. For a withdraw from the market, a 180-day notice to the state insurance commissioner and the subscriber, and that termination will be uniformly applied and not based on health status related factors of a covered individual

10.10 RESCISSION

After the second anniversary of the date the policy is issued, a misstatement, other than a fraudulent misstatement, made by the applicant in the application for the policy may not be used to void the policy or to deny a claim for loss incurred or disability beginning after that anniversary.

Otherwise, 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 Health reserves the right to retain premiums paid to offset any claim payment. A member will be notified of a rescission 30 days before cancellation of coverage.

SECTION 11. CLAIMS ADMINISTRATION & PAYMENT

11.1 SUBMISSION & PAYMENT OF CLAIMS

A claim is not payable until the service or supply has actually been received. Claims must be submitted within 90 days to Moda Health. Failure to provide written proof of loss within the required time does not invalidate or reduce any claim if it was not reasonably possible to give proof within the required time. In that case, the proof must be provided as soon as reasonably possible but no later than one year after the time proof is otherwise required, except in the event of a legal incapacity.

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

In most cases, in-network providers will submit claims directly to Moda Health. If members need to submit claims, they may either provide a notice of claim or download a claim form directly from the Moda Health website.

11.1.1 Notice of Claim

A written notice of a claim must be submitted to Moda Health before the 21st day after the date the expense was incurred, or as soon as reasonably possible. A notice given by or on behalf of the member to Moda Health at 601 SW Second Avenue, Portland, Oregon 97204, by fax at 855-522-9810, or to a Moda Health authorized agent, with information sufficient to identify the member, constitutes notice of claim.

11.1.2 Claim Forms

After receiving a notice of claim, Moda Health will provide claims forms to a member for filing proof of loss. If the forms are not provided before the 16th day after the date of the notice, a member can give proof in writing, set forth the nature and extent of the expenses incurred, and send the proof within the time stated in the Proof of Loss provision.

11.1.3 Proof of Loss

Written proof of loss must be provided to Moda Health at 601 SW Second Avenue, Portland, Oregon 97204 or by fax at 855-522-9810 within 90 days after the expense was incurred. Moda Health will not deny or reduce any claim if it was not reasonably possible to give proof within the required time.

11.1.4 Time of Payment of Claims

Indemnities payable under this policy for any loss, other than a loss for which this policy provides any periodic payment, will be paid immediately on receipt of due written proof of loss. Subject to due written proof of loss, all accrued indemnities for a loss for which this policy provides periodic payment will be paid within 30 days and any balance remaining unpaid on termination of liability will be paid immediately on receipt of due written proof of loss.

11.1.5 Payment of Claims

Benefits covered by this Policy will be paid to the member, except Moda Health will pay amounts due directly to a provider upon a member's written request. By paying benefits directly to a

provider, Moda Health is relieved of the obligation to pay, and of any liability for paying, those benefits to the member. Payment due at the time of a member's death will be paid in accordance with the beneficiary designation or to the estate.

11.1.6 Physical Examinations and Autopsy

Moda Health has the right and opportunity to have a person whose illness is the basis of a claim examined by a professional provider of its choice at its expense. This right may be used as often as reasonably required during the handling of a claim an, in the case of death, includes an autopsy, where it is not forbidden by law.

11.1.7 Hospital & Professional Provider Claims

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

Sometimes a hospital or professional provider will require a member, at the time of discharge or treatment, to pay charges for a service that the provider believes is not a covered expense. If this happens, the member must pay these amounts if he or she wishes to accept the service. Moda Health 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, he or she should send a copy of the bill to Moda Health and include all of the following information:

a. Patient's name
b. Subscriber's name and identification number
c. Date of service
d. Diagnosis with corresponding current ICD codes
e. Itemized description of the services and charges with corresponding American Medical Association CPT and/or Centers for Medicare and Medicaid HCPCS codes
f. Provider's tax ID number

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

For care received outside the United States, see section 11.1.11.

11.1.8 Ambulance Claims

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

11.1.9 Prescription Medication Claims

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

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

11.1.10 Vision Services Claims

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

11.1.11 Out-of-Country or Foreign Claims

When care is received outside the United States, the member must provide all of the following information to Moda Health:

a. Patient's name, subscriber's name and identification number
b. Statement explaining where the member was and why he or she 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

11.1.12 Explanation of Benefits (EOB)

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

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

11.1.13 Claim Inquiries

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

11.2 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.

11.2.1 Definitions

For purposes of section 11.2, the following definitions apply:

Adverse Benefit Determination means a letter or an Explanation of Benefits (EOB) from Moda Health denying initial eligibility (this notice will come from the Marketplace) or informing that a person is not eligible for benefits or that benefits have not been fully paid. Reasons are:

a. Rescission of coverage (section 10.10)
b. Eligibility to participate in the Plan
c. Network exclusion, annual benefit limit or other limitation on otherwise covered services

d. Utilization review that is a system for prospective, concurrent, or retrospective review of the medical necessity and appropriateness of health care services and a system for prospective, concurrent, or retrospective review to determine the experimental or investigational nature of health care services (does not include a review in response to an elective request for clarification of coverage)
e. A requested medication is not included in a drug formulary and the treating provider has determined that the medication is medically necessary
f. A denial of a step-therapy protocol exception request
g. Limitations or exclusions described in Section 8 and Section 9, including a decision that an item or service is experimental or investigational or not medically necessary
h. Continuity of care (section 11.3) is denied because the course of treatment is not considered active

A **Final Internal Adverse Benefit Determination** is an adverse benefit determination that has been upheld by Moda Health at the end of the internal appeal process, or the internal appeal process has been finished.

Appeal is an oral or written request by a member, a member's authorized representative or a member's provider for Moda Health or the 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 professional provider). A surrogate may be authorized by the court or act in accordance with state law on a member's behalf (court-appointed guardian, one with Durable Power of Attorney, healthcare proxy, or person designated under a healthcare consent statute)

Complaint means an oral or written expression of dissatisfaction about the utilization review process. A complaint does not include a request for information or clarification about any subject related to this policy. A complaint involving an adverse determination is an appeal of that adverse determination.

Experimental or Investigational means a healthcare treatment, service or device for which there is an early, developing scientific or clinical evidence demonstrating the potential efficacy or the treatment, service or device, but that is not yet broadly accepted as the prevailing standard of care

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

11.2.2 Time Limit for Submitting Appeals

A member, a member's authorized representative, or a member's provider has **180 days** from the date an adverse benefit determination is received to submit an appeal orally or in writing. If an appeal is not submitted within this timeframe, the member will lose the right to any appeal. If the adverse determination is related to a life-threatening condition or denial of prescription medications or intravenous infusions, members can request an external review directly.

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

The timelines in the sections below do not apply when the member does not reasonably cooperate, or circumstances beyond the control of either party makes it impossible to comply with the requirements. Whoever is unable to comply must give notice of the reason to the other party when the issue arises.

11.2.3 Appeals

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

Appeals of other adverse benefit determinations are administered by Moda Health. An appeal may be submitted orally or in writing. If necessary, Moda Health can provide assistance filing an appeal. Moda Health will acknowledge the receipt date of an appeal, include a list of relevant documents members must send for review, include an appeal form if the appeal is submitted orally and provide notice of the appeal provisions within 5 business days and conduct an investigation by persons who are not involved in the initial determination. The member may review the claim file and submit written comments, documents, records and other information to support the appeal.

Moda Health will finish the investigation and send a written notice of the decision to the member within 30 days of receiving the appeal, including the reason for the decision and information on the right to external review. For extension of coverage related to an acquired brain injury, Moda Health will respond by phone no later than 3 business days after receipt of an appeal (followed by a written notice sent within 30 days of receipt of the appeal).

Within 10 business days of an appeal denial, if a provider requests a specialty review, the case will be reviewed by Moda Health's employee or agent who holds the same or similar specialty as would typically manage the case being reviewed. Moda Health will finish the review within 15 business days after receipt of the request and send a notice in writing of the decision. A specialty review is voluntary and is not required before an external review.

11.2.4 Expedited (Fast) Appeal

Members may ask for a fast review on the following situations:

a. Denial of emergency care
b. Denial of continued hospitalization
c. Denial of another service to treat a life-threating condition or to prevent serious harm to the member as recommended by the treating provider with supporting documentation
d. Denial of prescription medications or intravenous medications a member is already taking
e. Denial of a step-therapy protocol exception request

Moda Health will finish a fast review no later than one business day or 72 hours, whichever is shorter, after receiving all information needed to make a decision and notify the member by phone or email. Within 3 business days, Moda Health will also send a written notice of the decision, including the reason for the decision and information on the right to external review.

11.2.5 External Review

If an internal appeal is denied, a member, a member's representative or a member's provider may ask to have the appeal reviewed by an independent review organization (IRO) appointed by MAXIMUS Federal Services at no cost to the member.

a. Request external review within 4 months of receiving a notice of the appeal determination by Moda Health.
b. Request an expedited (fast) external review for services related to life-threatening conditions or urgent care that would subject the member to severe pain that cannot be managed without the requested care or treatment, including denial of prescription medications or intravenous infusions, before the internal review requirement is exhausted.
c. Send an external request to MAXIMUS Federal Services by mail to 3750 Monroe Avenue, Suite 705, Pittsford, NY 14534, by fax at 1-888-866-6190 or online at externalappeal.com.
d. Include any additional information with the request.

The IRO will provide a written notice of the decision within:

a. 72 hours after receiving a fast appeal request
b. 20 days for other requests

Only certain types of denials are eligible for external review. The IRO screens requests, and will review appeals that relate to

a. An adverse benefit determination based on a utilization review decision
b. Cases in which Moda Health does not meet the internal timeline for review or the federal requirements for providing related information and notices
c. Rescission
d. A reasonable alternative standard for a reward under a wellness program
e. Compliance with the nonquantitative treatment limitation provisions for mental health and chemical dependency services
f. Whether surprise billing protections apply to an adverse benefit determination

The decision of the IRO is binding except to the extent other remedies are available to the member under state or federal law. If Moda Health fails to comply with the decision, the member may initiate a suit against Moda Health.

11.2.6 Complaints

Moda Health will review complaints about the utilization review process when submitted orally or in writing by a member, a member's authorized representative or a member's provider. Review of a complaint will be completed, and a written notice will be sent within 30 days.

11.2.7 Additional Member Rights

A member, a member's authorized representative or a member's provider has the right to file a complaint or ask for help from the Texas Department of Insurance.

Phone:	800-252-3439
Fax:	512-490-1007
Mail:	Texas Department of Insurance PO Box 149104 Austin, TX 78714-9104

Internet: www.tdi.texas.gov
email: ConsumerProtection@tdi.texas.gov

11.3 CONTINUITY OF CARE

Sometimes a provider's contract with the network ends. On the day a professional provider's contract with Moda Health ends, he or she becomes an out-of-network provider. When this happens, Moda Health may cover some services by the professional provider as if he or she were still in-network for a limited period of time. This is called continuity of care.

Moda Health will tell members who are under the care of a particular professional provider when this happens, and let them know about their right to continuity of care.

Eligible members

a. Will get a letter from Moda Health
    i. No later than 30 days before the contract ends, or as soon as Moda Health knows the contract is ending, or
    ii. If a professional provider's participation in the Plan is terminated for reasons relating to imminent harm, Moda Health may notify members immediately.
    iii. A professional provider that voluntarily terminates participation in the Plan shall provide reasonable notice to each member under the professional provider's care
    iv. When a member requests continuity of care before Moda Health sends its notice, the member is considered notified as of that date
b. Are under the care of a professional provider whose contract with Moda Health ends and the provider reasonably believes there are special circumstances that discontinuing care could cause harm to the member. Special circumstances include, but are not limited to:
    i. The care is an active course of treatment that is medically necessary, including a disability, an acute condition or a life-threatening illness
    ii. Pregnancy care is at least the second trimester
    iii. The professional provider and the member agree that it is a good idea to maintain continuity of care
    iv. Requests continuity of care from Moda Health

The professional provider must agree to follow the requirements of the medical services contract that had most recently been in effect between the professional provider and Moda Health, and to accept the contractual reimbursement applicable at the time the contract ended.

Continuity of care ends on the earlier of the following dates for most members:
    i. The day after the member finishes the active course of treatment that gives him or her the right to continuity of care
    ii. 90 days after the date the contract with the professional provider has ended
    iii. 9 months after the date the contract with the provider has ended if the member has been diagnosed with a terminal illness on the date the contract with the professional provider has ended

For pregnancy care that is past the second trimester, continuity of care may be extended through delivery of the child, immediate postpartum care, and the follow-up check-up within the first 6 weeks of delivery.

When continuity of care is not available:

a. The member is no longer covered by this policy
b. The subscriber ends the policy
c. The professional provider has moved out of the service area
d. The professional provider cannot continue to care for patients because of other reasons
e. The contract with the professional provider has ended for reasons related to quality of care and he or she has finished any appeal process

11.4 BENEFITS AVAILABLE FROM OTHER SOURCES

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

11.4.1 Coordination of Benefits (COB)

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

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

11.4.1.1 Order of Benefit 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, for example, 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, for example 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 are living together whether or not they have ever been married or domestic partners, 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 ever been married or domestic partners, 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. If the parent with responsibility has no health care coverage but the parent's spouse does, then the spouse's plan is primary. This rule applies to plan years beginning after the plan is given notice of the court decree.

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

d. **Dependent Child Covered by Individual Other than Parent**. For a dependent child covered under more than one plan of persons who are not the parents of the child, the first applicable provision (b or c) above shall determine the order of benefits as if those persons were the parents of the child.
e. **Dependent Child Covered by Parent and Spouse/Domestic Partner**. For a dependent child covered under the plans of both a parent and a spouse or domestic partner, the length of coverage provision below shall determine the order of benefits. If coverage under either or both parents' plans and the spouse's/domestic partner's plan began on the same day, the birthday rule will apply.
f. **Active/Retired or Laid Off Employee**. The plan that covers a member as an active employee, that is 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 the member as an employee, member of an organization, primary insured, or retiree or as a dependent of the same, is the primary plan and the COBRA or other continuation coverage is the secondary plan. If the other plan does not have this rule, and if, as a result the plans do not agree on the order of the benefits, this rule is ignored.
h. **Longer/Shorter Length of Coverage**. The plan that covered a member longer is the primary plan and the plan that covered the member for the shorter period of time is the secondary plan.
i. **None of the Above**. If the preceding rules do not determine the order of benefits, the allowable expenses shall be shared equally between the plans. In addition, this Plan will not pay more than it would have paid if it had been the primary plan.

11.4.1.2 How COB Works

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

The **secondary plan** (the plan that pays benefits after the primary plan) will reduce the benefits it pays so that payments from all plans are not more than 100% of the total allowable expense. The secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other healthcare coverage.

If the primary plan is a closed panel plan and the secondary plan is not, the secondary plan shall provide benefits as if it were the primary plan when a member uses an out-of-network provider,

except for emergency services or authorized referrals that are paid or provided by the primary plan.

11.4.1.3 Pharmacy COB

Claims subject to the COB provision of the Plan may be submitted electronically by pharmacies or through the direct member reimbursement paper claim process. The preferred method is for the pharmacy to electronically transmit the primary plan's remaining balance to Moda Health for processing. If approved, the secondary claim will be automatically processed according to plan benefits. Members who are unable to have their secondary claims processed electronically may submit a claim reimbursement request directly to Moda Health (see section 11.1.9).

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

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

Approved by Primary:

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

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

11.4.1.4 Definitions

For purposes of section 11.4.1, the following definitions apply:

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

Plan includes:

a. Group or individual insurance contracts and group-type contracts
b. HMO (health maintenance organization) coverage
c. Coverage under a labor-management trusteed plan, a union welfare plan, an employer organization plan or an employee benefits plan
d. Medical care components of group long-term care contracts, such as skilled nursing care
e. Subscriber contracts that pay or reimburse for the cost of dental care
f. Medical benefits coverage in automobile insurance contracts
g. Medicare or other government programs, other than Medicaid, and any other coverage required or provided by law
h. Other arrangements of insured or self-insured group or group-type coverage
i. Limited benefit coverage excluding disability income protection 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 long-term care policies
f. Medicare supplement policies and supplemental benefit coverage
g. Medicaid policies
h. Coverage under other federal governmental plans, unless permitted by law
i. Workers' compensation insurance coverage
j. The Texas Health Insurance Pool
k. An individual accident and health insurance policy that is designed to fully integrate with other policies through a variable deductible

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

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

a. The difference between the cost of a semi-private hospital room and a private hospital room, unless one of the plans provides coverage for private hospital room expenses
b. The amount of the reduction by the primary plan because a member has not complied with the plan's requirements concerning second surgical opinions or prior authorization, or because the member has a lower benefit due to not using an in-network provider
c. Any amount in excess of the highest reimbursement amount for a specific benefit, if a member is covered by 2 or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology
d. Any amount in excess of the highest of the negotiated fees, if a member is covered by 2 or more plans that provide benefits or services on the basis of negotiated fees
e. If a member is covered by one plan that calculates its benefits on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another plan that provides its benefits on the basis of negotiated fees, the primary plan's arrangement shall be the allowable expense for all plans. However, if the provider has contracted with the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the allowable expense used by the secondary plan to determine its benefits
f. If a plan is advised by a member that all plans covering the member are high-deductible health plans and the member intends to contribute to a health savings account established in accordance with Section 223 of the Internal Revenue Code of 1986, the

primary high-deductible health plan's deductible is not an allowable expense, except for any healthcare expense incurred that may not be subject to the deductible as described in Section 223(c)(2)(C)

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

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

Custodial parent means an individual who:

a. Is a managing conservator of a child or a possessory conservatory of a child who is a parent of the child; or
b. Is a guardian of the person or other custodian of a child and is designated as guardian or custodian by a court or administrative agency of Texas or another state.

11.4.2 Third Party Liability

A member may have a legal right to recover benefit or healthcare costs from a third party as a result of a medical condition for which such costs were paid by Moda Health. Because recovery from a third party may be difficult and take a long time, as a service to the member Moda Health will pay a member's expenses based on the understanding and agreement that Moda Health is entitled to be reimbursed from any recovery the member may receive for any benefits paid that are or may be recoverable from a third party no matter how the recovery is characterized. The amount that Moda Health will recover is governed by the Texas Civil Practice and Remedies Code, section 140.005.

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

11.4.2.1 Definitions:

For purposes of section 11.4.2, the following definitions apply:

Benefits means any amount paid by Moda Health or submitted 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 illness or injury, 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 may have received payment of medical expenses from Moda Health and may file a third party claim, but only seek the recovery of non-economic damages. In that case, Moda Health is still entitled to recover benefits as described in 11.4.2.

11.4.2.2 Subrogation

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

11.4.2.3 Right of Recovery

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

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

b. Consistent with the Texas Civil Practice and Remedies Code, section 140.005, Moda Health is entitled to receive the amount of benefits it has paid for an illness or injury out of any settlement or judgment that results from exercising the right of recovery against the third party. This is so whether or not the third party admits liability, or claims that the member is also at fault. In addition, Moda Health is entitled to receive the amount of benefits, consistent with the Texas Civil Practice and Remedies Code, section 140.005, it has paid whether the healthcare expenses are itemized or expressly excluded in the third party recovery.

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

11.4.2.4 Additional Provisions

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

a. The member shall cooperate with Moda Health to protect its recovery rights, including by:
   i. Signing and delivering any documents Moda Health reasonably requires to protect its rights, including a Third Party Reimbursement Questionnaire and Agreement. If the member has retained an attorney, then the attorney must also sign the agreement. Moda Health will not be required to pay benefits until the agreements is properly signed and returned.
   ii. Providing any information to Moda Health relevant to the application of the provisions of section 11.4.2, including all information available to the member, or any representative or attorney representing the member, relating to the potential

third party claim. This may include medical information, settlement correspondence, copies of pleadings or demands, and settlement agreements, releases or judgments

iii. Notifying Moda Health of the potential third party claim for which the Plan may issue benefits. The member has this responsibility even if the first request for payment of benefits is a bill or invoice submitted to Moda Health by the member's provider

iv. Taking such actions as Moda Health may reasonably request to assist it in enforcing its third party recovery rights

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

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

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

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

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

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

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

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

11.5 MEDICARE

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 Part B 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.

SECTION 12. MISCELLANEOUS PROVISIONS

12.1 ENTIRE CONTRACT; POLICY CHANGES

This policy, including the application, endorsements or amendments, is the entire contract of insurance. No change in this policy will be valid unless approved by Moda Health. Such approval must be attached to this policy. No agent has the authority to change this policy or waive any of its provisions.

12.2 INCONTESTABILITY

All statements made by a member in a signed application for coverage are representations and not warranties. No statement made for the purpose of obtaining coverage will be used to void, cancel or non-renew a member's coverage unless it is a written document signed by the subscriber, a signed copy of which is furnished to the subscriber. After the second anniversary of the date the policy is issued, a misstatement, other than a fraudulent misstatement, made by the applicant in the application for the policy may not be used to void the policy or to deny a claim for loss incurred or disability beginning after that anniversary.

12.3 CHANGE OF BENEFICIARY

Unless a member makes an irrevocably designation of beneficiary, the right to change a beneficiary is reserved for a member, and the consent of the beneficiary or beneficiaries is not required for the surrender or assignment of this policy, for any change of beneficiary or beneficiaries, or for any other changes in the policy

12.4 CONFORMITY WITH STATE STATUTES

Any provision of this policy that, on the effective date, conflicts with the statutes of the state of Texas is by this clause effectively amended to conform to the minimum requirements of Texas law.

12.5 DISCLOSURE OF BENEFIT REDUCTION

Moda Health will provide notification of material reductions in covered services or benefits to the subscriber no later than 30 days before the adoption of the change (more information in section 12.14).

12.6 RIGHT TO COLLECT & RELEASE NEEDED INFORMATION

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

12.7 CONFIDENTIALITY OF MEMBER INFORMATION

Keeping a member's protected health information confidential is very important to Moda Health. Protected health information includes enrollment, claims, and medical and dental information. Moda Health uses such information internally for claims payment, referrals and authorization of services, and business operations such as case management and quality management programs. Moda Health does not sell this information. The Notice of Privacy Practices provides more detail about how Moda Health uses members' information. A copy of the notice is available on the Moda Health website by following the HIPAA link or by calling 855-425-4192.

12.8 TRANSFER OF BENEFITS

Only members are entitled to benefits under this policy. These benefits are not assignable or transferable to anyone else, except when assignment to a provider is requested in writing by a member. Any other attempted assignment or transfer will not be binding on Moda Health, except that Moda Health shall pay amounts due under the Plan directly to a provider when billed by a provider licensed, certified or otherwise authorized by laws in the state of Texas or upon a member's written request.

12.9 RECOVERY OF BENEFITS PAID BY MISTAKE

If Moda Health mistakenly makes a payment for a member to which he or she is not entitled, or pays a person who is not eligible for payments at all, Moda Health has the right to recover the payment from the person paid or anyone else who benefited from it, including a provider. Moda Health'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.

12.10 CORRECTION OF PAYMENTS

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

12.11 MISSTATEMENT OF AGE

If the age of any member is incorrectly stated, Moda Health will make a fair adjustment of the premiums, benefits or both. The adjustment will be based on the premiums and benefits that would have been payable had Moda Health known the correct information.

12.12 RESPONSIBILITY FOR QUALITY OF MEDICAL CARE

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

12.13 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.

12.14 GUARANTEED RENEWABILITY

Moda Health 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:

a. For nonpayment of the required premiums by the subscriber. (Moda Health will terminate the policy with 10 days' notice if premiums are not received when due)
b. For fraud or misrepresentation by a member
c. When a member is enrolled in Medicare
d. When Moda Health discontinues offering and/or renewing its individual health benefit plans in a specified service area within Texas.
e. When, in the case of an individual health benefit plan that delivers covered services through a specified network of healthcare providers, the member no longer lives, resides or works in the service area of the provider network and the termination of coverage is not related to the health status of any member
f. When, in the case of a health benefit plan that is offered in the individual market only through one or more bona fide associations, the membership of a person in the association ceases and the termination of coverage is not related to the health status of any member

Moda Health may modify an individual health benefit plan at the time of coverage renewal. The modification is not a discontinuation as described under paragraph (c) of this section.

12.15 NO WAIVER

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

12.16 COMPLIANCE WITH FEDERAL & STATE MANDATES

Moda Health provides benefits in accordance with the requirements of all applicable state and federal laws and as described in this policy. This includes compliance with federal mental health parity requirements and coverage of essential health benefits as defined by the Affordable Care Act, except that the policy does not provide the required pediatric dental coverage. Members must obtain separate pediatric dental coverage through a Marketplace certified pediatric dental plan. This applies whether the member is an adult or a child. A list of Marketplace certified pediatric dental plans can be found at the Marketplace website.,

Members who have not met the requirement to obtain pediatric dental coverage should contact the Marketplace for assistance.

12.17 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 Texas. Any provision of this policy governed by state law that conflicts with the laws of the state of Texas is, by this clause, amended to conform to the minimum requirements of the laws of the state of Texas.

12.18 LEGAL ACTION

Any legal action arising out of, or related to, this policy and filed against Moda Health by a member or any third party must be filed in court at least 60 days, but no more than 3 years, after the time the claim was filed (see section 11.1). All internal levels of appeal under the Plan must be exhausted before filing a legal action in court.

12.19 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 Texas.

12.20 EVALUATION OF NEW TECHNOLOGY

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

12.21 REPORTING HEALTHCARE FRAUD

Moda Health's mission is to make healthcare smart and simple. Its goal is to empower members with information to help guide their health care decision, including how to protect themselves against healthcare fraud.

Healthcare fraud occurs when someone intentionally provides false or misleading information to obtain health benefits or money. Healthcare fraud is a crime.

Healthcare fraud places a burden on both Moda Health and members. Providers who engage in fraud may be willing to prioritize their own financial gain over quality of treatment and diagnosis. Also, healthcare fraud raises the cost of health insurance for everyone.

Healthcare fraud can be committed by a number of people including providers, hospitals, labs, medical equipment suppliers, and even members.

Examples of provider fraud:

a. Billing for services that were not performed
b. Using a falsified diagnosis to bill tests or procedures that are not medically necessary
c. Upcoding or billing for more expensive services than the ones that were performed
d. Accepting money from another provider for member referrals or a kickback
e. Waiving a member's cost sharing in order to bill the insurer more

Examples of member fraud:

a. Using someone else's plan coverage or ID card
b. Falsely alleging the theft of medical equipment
c. Reselling medical items

Moda Health keeps member personal health data safe, and it is important that members take steps to protect their information as well.

When a member goes to the doctor, the member should ask questions about the care received. Once a member receives a medical bill from a provider, the bill should be compared to the member's plan explanation of benefits. If a member has questions about what was charged, the member should contact Customer Service. If a member has any questions about the claim procedure or the review procedure, the member should contact Customer Service or visit Moda Health website.

Moda Health has a Special Investigations Unit (SIU) to investigate allegations of fraud. If a member suspects fraud, report concerns to Moda Health's Special Investigations Unit.

By email: stopfraud@modahealth.com
By phone: 855-801-2991
By mail: Attn: Special Investigations Unit
Moda Health Plan, Inc.
604 SW Second Avenue
Portland, OR 97204

When leaving a message to SIU, please provide as much information as possible (names of those involved, locations, and any other details), so that Moda Health can investigate and take appropriate action. Moda Health does not trace calls and will not try to identify the caller. Reports can be made without worry of retaliation or intimidation

SECTION 13. MEMBERS' RIGHTS AND RESPONSIBILITIES

13.1 What are members' rights and responsibilities?

Members have the right to:

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

Members have the responsibility to:

a. Read this policy and make sure they understand the policy. 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 him or her to provide good healthcare
f. Participate in making decisions about their medical care and forming a treatment plan
g. Follow plans and instructions for care they have agreed to with their provider
h. Use urgent and emergency services appropriately
i. Show their medical identification card when seeking medical care
j. Tell providers about any other insurance policies that may provide coverage
k. Reimburse Moda Health from any third party payments they may receive
l. Provide information Moda Health needs to properly administer benefits and resolve any issues or concerns that may arise

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

13.2 What are my rights under the Women's Health and Cancer Rights Act of 1998 (WHCRA)?

The Plan provides benefits for mastectomy related services, including all states of reconstruction and surgery to achieve symmetry between the breasts, prostheses and complications resulting from a mastectomy, including lymphedema. Contact Customer Service for more information.

SECTION 14. MANDATORY NOTICES

BALANCE BILL NOTICE

ALTHOUGH HEALTH CARE SERVICES MAY BE OR HAVE BEEN PROVIDED TO YOU AT A HEALTH CARE FACILITY THAT IS A MEMBER OF THE PROVIDER NETWORK USED BY YOUR HEALTH BENEFIT PLAN, OTHER PROFESSIONAL SERVICES MAY BE OR HAVE BEEN PROVIDED AT OR THROUGH THE FACILITY BY PHYSICIANS AND OTHER HEALTH CARE PRACTITIONERS WHO ARE NOT MEMBERS OF THAT NETWORK. YOU MAY BE RESPONSIBLE FOR PAYMENT OF ALL OR PART OF THE FEES FOR THOSE PROFESSIONAL SERVICES THAT ARE NOT PAID OR COVERED BY YOUR HEALTH BENEFIT PLAN UNLESS BALANCE BILLING FOR THOSE SERVICES IS PROHIBITED

TEXAS DEPARTMENT OF INSURANCE NOTICE

- An exclusive provider benefit plan provides no benefits for services you receive from out-of-network providers, with specific exceptions as described in your policy and below.
- You have the right to an adequate network of preferred providers (known as “network providers”).
    - If you believe that the network is inadequate, you may file a complaint with the Texas Department of Insurance.
- If your insurer approves a referral for out-of-network services because no preferred provider is available, or if you have received out-of-network emergency care, your insurer must, in most cases, resolve the nonpreferred provider’s bill so that you only have to pay any applicable coinsurance, copay, and deductible amounts.
- You may obtain a current directory of preferred providers at the following website: www.modahealth.com or by calling 844-827-6571 for assistance in finding available preferred providers. If you relied on materially inaccurate directory information, you may be entitled to have an out-of-network claim paid at the in-network level of benefits.

NOTICE OF CERTAIN MANDATORY BENEFITS

This notice is to advise you of certain coverage and/or benefits provided by your contract with Moda Health.

Mastectomy or Lymph Node Dissection
Minimum Inpatient Stay: If due to treatment of breast cancer, any person covered by this plan has either a mastectomy or a lymph node dissection, this plan will provide coverage for inpatient care for a minimum of:

(a) 48 hours following a mastectomy, and
(b) 24 hours following a lymph node dissection.

The minimum number of inpatient hours is not required if the covered person receiving the treatment and the attending physician determine that a shorter period of inpatient care is appropriate.

Prohibitions: We may not

(a) deny any covered person eligibility or continued eligibility or fail to renew this plan solely to avoid providing the minimum inpatient hours;
(b) provide money payments or rebates to encourage any covered person to accept less than the minimum inpatient hours;
(c) reduce or limit the amount paid to the attending physician, or otherwise penalize the physician, because the physician required a covered person to receive the minimum inpatient hours; or
(d) provide financial or other incentives to the attending physician to encourage the physician to provide care that is less than the minimum hours.

If any person covered by this plan has questions concerning the above, please call Moda Health at 844-827-6571, or write us at 601 SW Second Avenue, Portland, Oregon 97204.

Form Number 349 Mastectomy

NOTICE OF CERTAIN MANDATORY BENEFITS

This notice is to advise you of certain coverage and/or benefits provided by your contract with Moda Health.

Coverage and/or Benefits for Reconstructive Surgery After Mastectomy-Enrollment
Coverage and/or benefits are provided to each covered person for reconstructive surgery after mastectomy, including:

(a) all stages of the reconstruction of the breast on which mastectomy has been performed;
(b) surgery and reconstruction of the other breast to achieve a symmetrical appearance; and
(c) prostheses and treatment of physical complications, including lymphedemas, at all stages of mastectomy.

The coverage and/or benefits must be provided in a manner determined to be appropriate in consultation with the covered person and the attending physician.

Prohibitions: We may not

(a) offer the covered person a financial incentive to forego breast reconstruction or waive the coverage and/or benefits shown above;
(b) condition, limit, or deny any covered person's eligibility or continued eligibility to enroll in the plan or fail to renew this plan solely to avoid providing the coverage and/or benefits shown above; or;
(c) reduce or limit the amount paid to the physician or provider, nor otherwise penalize, or provide a financial incentive to induce the physician or provider to provide care to a covered person in a manner inconsistent with the coverage and/or benefits shown above.

If any person covered by this plan has questions concerning the above, please call Moda Health at 844-827-6571, or write us at 601 SW Second Avenue, Portland, Oregon 97204.

Form Number 1764 Reconstructive Surgery After Mastectomy - Enrollment

NOTICE OF CERTAIN MANDATORY BENEFITS

This notice is to advise you of certain coverage and/or benefits provided by your contract with Moda Health.

Examinations for Detection of Prostate Cancer
Benefits are provided for each covered male for an annual medically recognized diagnostic examination for the detection of prostate cancer. Benefits include:

(a) a physical examination for the detection of prostate cancer; and
(b) a prostate-specific antigen test for each covered male who is
(1) at least 50 years of age; or
(2) at least 40 years of age with a family history of prostate cancer or other prostate cancer risk factor.

If any person covered by this plan has questions concerning the above, please call Moda Health at 844-827-6571, or write us at 601 SW Second Avenue, Portland, Oregon 97204.

Form Number 258 Prostate

NOTICE OF CERTAIN MANDATORY BENEFITS

This notice is to advise you of certain coverage and/or benefits provided by your contract with Moda Health.

Inpatient Stay following Birth of a Child

For each person covered for maternity/childbirth benefits, we will provide inpatient care for the mother and her newborn child in a health care facility for a minimum of:

(a) 48 hours following an uncomplicated vaginal delivery, and
(b) 96 hours following an uncomplicated delivery by cesarean section.

This benefit does not require a covered female who is eligible for maternity/childbirth benefits to:

(a) give birth in a hospital or other health care facility, or
(b) remain in a hospital or other health care facility for the minimum number of hours following birth of the child.

If a covered mother or her newborn child is discharged before the 48 or 96 hours has expired, we will provide coverage for postdelivery care. Postdelivery care includes parent education, assistance and training in breast-feeding and bottle-feeding and the performance of any necessary and appropriate clinical tests. Care will be provided by a physician, registered nurse or other appropriate licensed health care provider, and the mother will have the option of receiving the care at her home, the health care provider's office or a health care facility.

Since we provide in home postdelivery care, we are not required to provide the minimum number of hours outlined above unless (a) the mother's or child's physician determines the inpatient care is medically necessary, or (b) the mother requests the inpatient stay.

Prohibitions: We may not

(a) modify the terms of this coverage based on any covered person requesting less than the minimum coverage required;
(b) offer the mother financial incentives or other compensation for waiver of the minimum number of hours required;
(c) refuse to accept a physician's recommendation for a specified period of inpatient care made in consultation with the mother if the period recommended by the physician does not exceed guidelines for prenatal care developed by nationally recognized professional associations of obstetricians and gynecologists or pediatricians;
(d) reduce payments or reimbursements below the usual and customary rate; or
(e) penalize a physician for recommending inpatient care for the mother and/or the newborn child.

If any person covered by this plan has questions concerning the above, please call Moda Health at 844-827-6571, or write us at 601 SW Second Avenue, Portland, Oregon 97204.

Form Number 102 Maternity

NOTICE OF CERTAIN MANDATORY BENEFITS

This notice is to advise you of certain coverage and/or benefits provided by your contract with Moda Health.

Coverage for Tests for Detection of Colorectal Cancer
Benefits are provided, for each person enrolled in the plan who is 50 years of age or older and at normal risk for developing colon cancer, for expenses incurred in conducting a medically recognized screening examination for the detection of colorectal cancer. Benefits include the covered person's choice of:

(a) a fecal occult blood test performed annually and a flexible sigmoidoscopy performed every five years, or
(b) a colonoscopy performed every 10 years.

If any person covered by this plan has questions concerning the above, please call Moda Health at 844-827-6571, or write us at 601 SW Second Avenue, Portland, Oregon 97204.

Form Number 1467 Colorectal Cancer Screening

NOTICE OF CERTAIN MANDATORY BENEFITS

This notice is to advise you of certain coverage or benefits provided by your contract with Moda Health.

Coverage of Tests for Detection of Human Papillomavirus, Ovarian Cancer, and Cervical Cancer

Coverage is provided for each woman enrolled in the plan who is 18 years of age or older for expenses incurred for an annual, medically recognized diagnostic examination for the early detection of ovarian and cervical cancer. Coverage required under this section includes a CA 125 blood test and, at a minimum, a conventional Pap smear screening or a screening using liquid-based cytology methods, as approved by the FDA, alone or in combination with a test approved by the FDA for the detection of the human papillomavirus.

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

ATENCIÓN: Si habla español, hay disponibles servicios de ayuda con el idioma sin costo alguno para usted. Llame al 888-217-2363 (TTY: 711).

CHÚ Ý: Nếu bạn nói tiếng Việt, có dịch vụ hỗ trợ ngôn ngữ miễn phí cho bạn. Gọi 888-217-2363 (TTY:711)

注意：如果您說中文，可得到免費語言幫助服務。請致電888-217-2363（聾啞人專用：711）

주의: 한국어로 무료 언어 지원 서비스를 이용하시려면 다음 연락처로 연락해주시기 바랍니다. 전화 888-217-2363 (TTY: 711)

PAUNAWA: Kung nagsasalita ka ng Tagalog, ang mga serbisyong tulong sa wika, ay walang bayad, at magagamit mo. Tumawag sa numerong 888-217-2363 (TTY: 711)

تنبيه: إذا كنت تتحدث العربية، فهناك خدمات مساعدة لغوية متاحة لك مجانًا. اتصل برقم 888-217-2363 (الهاتف النصي: 711)

توجہ دیں: اگر آپ اردو (URDU) بولتے ہیں تو آپ کے لیے بلا معاوضہ دستیاب لسانی اعانت 888-217-2363 (TTY: 711) پر کال کریں ہے۔

ВНИМАНИЕ! Если Вы говорите по-русски, воспользуйтесь бесплатной языковой поддержкой. Позвоните по тел. 888-217-2363 (текстовый телефон: 711).

ATTENTION : si vous êtes locuteurs francophones, le service d'assistance linguistique gratuit est disponible. Appelez au 888-217-2363 (TTY : 711)

توجه: در صورتی که به فارسی صحبت می کنید، خدمات ترجمه به صورت رایگان برای شما موجود است. با 888-217-2363 (TTY: 711) تماس بگیرید.

ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपको भाषाई सहायता बिना कोई पैसा दिए उपलब्ध है। 888-217-2363 पर कॉल करें (TTY: 711)

Achtung: Falls Sie Deutsch sprechen, stehen Ihnen kostenlos Sprachassistenzdienste zur Verfügung. Rufen sie 888-217-2363 (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。888-217-2363（TYY、テレタイプライターをご利用の方は711）までお電話ください。

અગત્યનું: જો તમે (ભાષાંતર કરેલ ભાષા અહીં દર્શાવો) બોલો છો તો તે ભાષામાં તમારે માટે વિના મૂલ્યે સહાય ઉપલબ્ધ છે. 888-217-2363 (TTY: 711) પર કૉલ કરો

ໂປດຊາບ: ຖ້າທ່ານເວົ້າພາສາລາວ, ການຊ່ວຍເຫຼືອດ້ານພາສາແມ່ນມີໃຫ້ທ່ານໂດຍບໍ່ເສັຽຄ່າ. ໂທ 888-217-2363 (TTY: 711)

УВАГА! Якщо ви говорите українською, для вас доступні безкоштовні консультації рідною мовою. Зателефонуйте 888-217-2363 (TTY: 711)

ATENŢIE: Dacă vorbiți limba română, vă punem la dispoziție serviciul de asistență lingvistică în mod gratuit. Sunați la 888-217-2363 (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 888-217-2363 (TTY: 711)

ត្រូវចងចាំ៖ បើអ្នកនិយាយភាសាខ្មែរ ហើយ ត្រូវការសេវាកម្មជំនួយផ្នែកភាសាដោយ ឥតគិតថ្លៃ គឺមានផ្តល់ជូនលោកអ្នក។ សូមទូរស័ព្ទ ទៅកាន់លេខ 888-217-2363 (TTY: 711)

HUBACHIISA: Yoo afaan Kshtik kan dubbattan ta'e tajaajiloonni gargaarsaa isiniif jira 888-217-2363 (TTY:711) tiin bilbilaa.

โปรดทราบ: หากคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือด้านภาษาได้ฟรี โทร 888-217-2363 (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 888-217-2363 (TTY: 711)

IPANGAG: Nu agsasaoka iti Ilocano, sidadaan ti tulong iti lengguahe para kenka nga awan bayadna. Umawag iti 888-217-2363 (TTY: 711)

UWAGA: Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń: 888-217-2363 (obsługa TTY: 711)

modahealth.com

moda HEALTH

For help, call us directly at 844-827-6571
(En Español: 888-786-7461)

P.O. Box 40384
Portland, OR 97240