Alaska
Individual Policy

Inside Exchange

Be Equipped – CSV2 (Providence) (Silver) Plan
($500 Deductible Plan)

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.

Moda Health renews this individual plan on January 1st each year, including benefit and rate adjustments. Rates may also change when the family composition changes, with new rates effective the 1st of the following month.

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

TABLE OF CONTENTS

SECTION 1. WELCOME

Moda Health is pleased to provide individual health coverage to members through the Individual Be Equipped Silver PPO Plan. This policy is designed to provide members important information about the Plan's benefits, limitations and procedures.

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

Moda Health reserves the right to monitor telephone conversations and e-mail communications between its employees and its customers 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 myModa, accessed through the Moda Health website. All provisions are governed by this policy between the subscriber and Moda Health.

1.1 MEMBER RESOURCES

Moda Health Website (log in to **myModa**)
www.modahealth.com

Medical Customer Service Department
Toll-free 844-274-9117; Llamado gratis 888-786-7461

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

Pharmacy Customer Service Department
Toll-Free 888-361-1610

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

Telecommunications Relay Service for the hearing impaired
711

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

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

Beech Street Network
www.beechstreet.com

SECTION 2. SUMMARY OF BENEFITS – A QUICK REFERENCE

This section is a quick reference summarizing the Plan's benefits. The details of the actual benefits and the conditions, limitations and exclusions are contained in the sections that follow. An explanation of important terms is found in Section 5.

Section 3.1 provides information regarding prior authorization requirements. Members can access a complete list of procedures that require prior authorization on myModa or by contacting Customer Service. Failure to obtain required prior authorizations may result in denial of benefits or a penalty.

2.1 NETWORK INFORMATION

To receive maximum benefits members should seek service from in-network providers. Members will have higher out-of-pocket costs if they utilize providers who are not in the network. An out-of-network provider has the right to bill the difference between the maximum plan allowance and the actual charge. This difference will be the member's responsibility in addition to any cost sharing, cost containment penalties and disallowed charges.

In-network benefits and out-of-network benefits are determined as shown:

<table>
<tr><th rowspan="2"></th><th colspan="2">Reimbursement Benefit Level</th></tr>
<tr><th>In Alaska</th><th>Outside of Alaska</th></tr>
<tr><td>In-network providers</td><td colspan="2" rowspan="2">In-Network Benefit</td></tr>
<tr><td>In-network hospital</td></tr>
<tr><td>Out-of-network providers</td><td>In-Network Benefit</td><td>Out-of-Network Benefit</td></tr>
<tr><td>Out-of-network hospitals</td><td>In-Network Benefit
(if located more than 50 miles from an in-network hospital)</td><td>Out-of-Network Benefit</td></tr>
<tr><td>Alaska Regional hospitals located within 50 miles of a Providence hospital</td><td colspan="2">Out-of-Network Benefit</td></tr>
</table>

Members may choose an in-network provider by using "Find Care" on myModa and checking the Beech Street website, or by contacting Customer Service for assistance. Member ID cards will identify the applicable network(s).

Network
For all members:
Medical Network is Endeavor Providence
Pharmacy Network is MedImpact
Dental network is Delta Dental Premier Network

2.1.1 Coverage Outside Alaska and Outside the Service Area for Children

Plan benefits will be extended to enrolled children residing in the United States but outside Alaska as if the care were rendered by in-network providers, subject to the following limitations:

a. All non-emergency hospital confinements must be prior authorized

b. Services will be paid at the in-network benefit level if provided within a 50-mile radius of the child's residence or at the closest appropriate facility
c. Services will be paid at the out-of-network benefit level if such services are provided outside the 50-mile radius of the child's residence
d. Out-of-network providers may bill members for charges in excess of the maximum plan allowance

2.2 SCHEDULE OF BENEFITS

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.

All "annual" or "per year" benefits accrue on a calendar year basis unless otherwise specified.

	In-Network Benefits	**Out-of-Network Benefits**
Annual deductible per member	**$ 500**	**$ 3,500**
Maximum annual family aggregate deductible	**$1,000**	**$ 7,000**
Annual out-of-pocket maximum per member	**$1,500**	**$13,700**
Maximum annual aggregate out-of-pocket maximum per family	**$3,000**	**$27,400**

Services	**Cost Sharing** (Deductible applies unless noted differently)		**Section in Handbook & Details**
	In-Network	**Out-of-Network**[†]	
Emergency Care			
Emergency Room Facility	30%	30%	Section 6.3 In-network deductible and out-of-pocket maximum apply to all services
Hospital and Residential Facility Care			
Inpatient Acute Care	30%	50%	Section 6.4.3
Inpatient Rehabilitation	30%	50%	Section 6.4.4 30 days per year
Skilled Nursing Facility Care	30%	50%	Section 6.4.5 60 days per year
Residential Mental Health & Chemical Dependency Treatment Programs	30%	50%	Section 6.4.6
Chemical Dependency Detoxification	30%	50%	Section 6.4.7

Services	Cost Sharing (Deductible applies unless noted differently)		Section in Handbook & Details
	In-Network	Out-of-Network[†]	
Ambulatory Services			
Outpatient Surgery and Invasive Diagnostic Procedures (Facility Charges)	30%	50%	Section 6.5.1
Outpatient Rehabilitation and Habilitation	$30,deductible waived	50%	Section 6.5.2 45 sessions per year
Infusion Therapy (Home or Outpatient)	30%	50%	Section 6.5.3
Diagnostic X-ray and Lab	30%	50%	Section 6.5.4
Therapeutic X-ray	30%	50%	Section 6.5.5
Kidney Dialysis	30%	50%	Section 6.5.5
Imaging Procedures	30%	50%	Section 6.5.6
Outpatient Chemical Dependency Services	$30,deductible waived	50%	Section 6.5.7
Professional Services			
Preventive Healthcare			Section 6.6.1
Services as required under the Affordable Care Act, including the following:	No cost sharing	50%	
Well-Baby Exams	No cost sharing	50%	First 24 months of life
Newborn Hearing Screening	No cost sharing	50%	Within 30 days of birth
Routine Vision Screening	No cost sharing	50%	Age 3-5
Periodic Health Exams	No cost sharing	50%	3 exams age 2 - 4 One per year, age 5+
Immunizations	No cost sharing	50%	
Women's Exam & Pap Test	No cost sharing	50%	One per year
Routine Mammogram	No cost sharing	50%	One age 35 - 40 One per year, age 40+
Routine Colonoscopy	No cost sharing	50%	One per 10 years, age 50+
Routine Diagnostic X-ray and Lab	30%	50%	
Prostate Rectal Exam	$30,deductible waived	50%	One per year, age 40+
Prostate Specific Antigen (PSA) Test	30%	50%	One per year, age 40+
Home and Office Visits (including naturopath visits)	$30, deductible waived	50%	Section 6.6.3

Services	Cost Sharing (Deductible applies unless noted differently)		Section in Handbook & Details
	In-Network	Out-of-Network[†]	
Specialist Visits	$30, deductible waived	50%	Section 6.6.3
Urgent Care Office Visits	$30, deductible waived	50%	Section 6.6.3
Physician Hospital Visits	30%	50%	Section 6.6.3
Outpatient Diabetic Instruction	30%	50%	Section 6.6.5
Therapeutic Injections	30%	50%	Section 6.6.6
Surgery	30%	50%	Section 6.6.7
Pediatric Dental Care			Section 6.6.12 Under age 19 Frequency limits apply to some services
Preventive and Diagnostic	No cost sharing	50%	
Other dental services	30%	50%	
Orthodontia	50%	50%	Waiting period applies
Special Dental Care	30%	50%	Section 6.6.13
Alternative Care			Section 6.6.15
Spinal Manipulation	$30, deductible waived	50%	12 visits per year
Acupuncture	$30, deductible waived	50%	12 visits per year
Nutritional Therapy	30%	50%	Section 6.6.16
Outpatient Mental Health Services	$30, deductible waived	50%	Section 6.6.18
Outpatient Psychological or Neuropsychological Testing	$30, deductible waived	50%	Section 6.6.19 12 hours per year
Applied Behavior Analysis			Section 6.6.20
Office Visits	$30, deductible waived	50%	
Other Services	30%	50%	
Other Services			
Ambulance Transportation	30%	30% (in-network deductible and out-of-pocket maximum apply)	Section 6.7.1
Commercial Transportation	30%	30%	Section 6.7.2 One-way for sudden, life-endangering medical condition
Hospice Care			Section 6.7
Home Care	30%	50%	
Inpatient Care	30%	50%	10 days

Services	Cost Sharing (Deductible applies unless noted differently)		Section in Handbook & Details
	In-Network	Out-of-Network[†]	
Respite Care	30%	50%	240 hours
Maternity	30%	50%	Section 6.7.4
Breastfeeding Support, Supplies and Counseling	No cost sharing	No cost sharing	Section 6.7.5
Transplant			Section 6.7.6 Includes donor costs
Exclusive transplant network facilities	30%	N/A	
Other facilities	Not covered	Not covered	
Travel, Lodging & Meals	30%	30%	$7,500 per transplant
Home Healthcare	30%	50%	Section 6.7.7 130 visits per year
Outpatient Durable Medical Equipment	30%	50%	Section 6.7.8
Supplies and Appliances	30%	50%	Section 6.7.8 One pair of orthotics or orthopedic shoes per year if not related to treating diabetes
Disposable Supplies (provided in a professional provider's office)	30%	50%	Section 6.7.8
Hearing Exam and Hardware	30%	50%	Section 6.7.10 Services once in a 3-year period
Pediatric Vision Care			Section 6.7.11 Under age 19
Exam	30%	50%	One per year
Lenses & frames or contacts	30%	50%	One pair per year
Optional lenses and treatments	30%	N/A	
Low vision evaluation	30%	50%	One every 5 years
Low vision services	30%	50%	4 visits every 5 years for follow up care
Low vision aids	30%	50%	One low vision aid per year and one pair of high power spectacles per year
Adult Vision Care	30%	50%	Section 6.7.12 Age 19 and older Exams and lenses & frames once every year

Services	Cost Sharing (Deductible applies unless noted differently)		Section in Handbook & Details
	In-Network	Out-of-Network†	
Medications			
Injectable Medication	30%	50%	Section 6.8.1
Prescription Medication			Section 6.9 Up to 90-day supply for retail and mail order One copay for each 30 day supply Deductible waived
Value	$2	$2	
Select	$20	$20	
Preferred	35%	35%	
Brand and Specialty	45%	45%	Up to 30-day supply per prescription for specialty pharmacy
Additional Accident Benefit			
Additional Accident Benefit	No cost sharing	No cost sharing	Section 6.10 $1,000 maximum. Services must be completed within 90 days of the injury

† All professional services provided in Alaska will be paid at the in-network benefit level, subject to the deductible, and accrue toward the in-network out-of-pocket maximum. In Alaska, all hospital services except those provided by out-of-network hospitals located within 50 miles of an in-network hospital will be reimbursed at the in-network benefit level, subject to the deductible, and accrue toward the in-network out-of-pocket maximum.

2.3 DEDUCTIBLES

The Plan has an annual deductible. The deductible amounts are shown in section 2.2, and are the amount of covered expenses that are paid by members before benefits are payable by the Plan. In-network and out-of-network amounts accumulate separately. After the deductible has been satisfied, benefits will be paid according to section 2.2.

	Covered expenses accrue toward the deductible	
	In Alaska	**Outside of Alaska**
In-network providers In-network hospital	In-Network deductible	
Out-of-network providers	In-Network deductible	Out-of-Network deductible
Out-of-network hospitals	In-Network deductible (if located more than 50 miles from an in-network hospital)	Out-of-Network deductible
Alaska Regional hospitals located within 50 miles of a Providence hospital	Out-of-Network deductible	

When a per member deductible is met, benefits for that member will be paid according to section 2.2. If coverage is for more than one member, the per member deductible applies only until the total family deductible is reached.

Copayments and disallowed charges do not apply to the deductible.

2.4 ANNUAL MAXIMUM OUT-OF-POCKET

After the annual out-of-pocket maximum is met, the Plan will pay 100% of covered services for the remainder of the year. If coverage is for more than one member, the per member maximum applies only until the total family out-of-pocket maximum is reached. In-network and out-of-network out-of-pocket maximums accumulate separately and are not combined.

Expenses accumulate toward the annual out-of-pocket maximum as shown:

	Out-of-pocket covered expenses accrue toward	
	In Alaska	**Outside of Alaska**
In-network providers In-network hospital	In-network out-of-pocket maximum	
Out-of-network providers	In-network out-of-pocket maximum	Out-of-network out-of-pocket maximum
Out-of-network hospitals	In-network out-of-pocket maximum (if located more than 50 miles from an in-network hospital)	Out-of-network out-of-pocket maximum
Alaska Regional hospitals located within 50 miles of a Providence hospital	Out-of-Network out-of-pocket maximum	

Members are responsible for the following costs (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):

a. Cost containment penalties
b. Disallowed charges
c. Vision benefits for members over age 18
d. Hearing coverage benefits

2.5 PAYMENT

Expenses allowed by Moda Health are based upon the maximum plan allowance, which is a contracted fee for in-network providers and for out-of-network providers is an amount established, reviewed, and updated by a national database. Depending upon the plan provisions, cost sharing may apply.

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.

SECTION 3. COST CONTAINMENT

The following special cost containment provisions may affect how benefits are paid.

3
3.1 PRIOR AUTHORIZATION REQUIREMENTS

When a professional provider suggests admission to the hospital or a residential program, or a non-emergency surgery, the member should ask the provider to contact Moda Health for prior authorization. The hospital, professional provider, and member are notified of the outcome of the authorization process by letter.

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

The prior authorization penalty does not 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.

A member may obtain authorization information by contacting Customer Service. For mental health of chemical dependency services, contact Behavioral Health Customer Service. See Exhibit A for a list of services and medications requiring prior authorization.

3.1.1 Inpatient Services and Residential Programs

All non-emergency hospital confinements that are scheduled in advance, and admission to any residential treatment program, must be prior authorized in order for maximum plan benefits to be payable. If the hospital stay is not medically necessary, claims will be denied. Moda Health will authorize medically necessary lengths of stay based upon the medical condition. Additional hospital days are covered only upon medical evidence of need.

Authorization for emergency hospital admissions must be obtained by calling Moda Health within 48 hours of the emergency hospital admission (or as soon as reasonably possible).

3.1.2 Ambulatory Surgery and Other Outpatient Services

The Plan requires prior authorization for many outpatient services. Prior authorization must be obtained for any inpatient admission or overnight stay for a service that is commonly performed on an outpatient basis. Some outpatient or ambulatory services also require prior authorization. Any covered benefit will be based on the cost of the most appropriate setting for the procedure.

3.1.3 Prescription Medication

A complete list of medications that require prior authorization is available on myModa or by contacting Customer Service. The member, provider or pharmacy should contact Customer Service for prior authorization.

Prior authorization programs are not intended to create barriers or limit access to medications. Medications requiring prior authorization are evaluated with respect to evidence based criteria that align with medical literature, best practice clinical guidelines and guidance from the FDA. Requiring prior authorization ensures member safety, promotes proper use of medications and supports cost effective treatment options for all members.

3.2 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.

3.3 COST EFFECTIVENESS SERVICES

Cost effectiveness services are services or supplies that are not otherwise benefits of the Plan, 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, cost effective services agreed upon by a member and his or her professional provider and Moda Health will be covered. Any party can also provide notification in writing and terminate such services.

The fact that the Plan has paid benefits for cost effectiveness 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 cost effectiveness services for the same member. All amounts paid for cost effectiveness services under this provision shall be included in computing any benefits, limitations or cost sharing under the Plan.

SECTION 4. CARE COORDINATION

4

4.1 CARE COORDINATION

The Plan provides individualized coordination of complex or catastrophic cases. Care Coordinators and Case Managers who are 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.

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.

Toll-free: 800-592-8283
Office Hours – Monday through Friday
6:00 AM to 4:30 PM (Alaskan Time)

SECTION 5. DEFINITIONS

Ambulatory Care means medical care provided on an outpatient basis. Ambulatory care is given to members who are not confined to a hospital.

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 his or her professional license.

Autism Spectrum Disorders means pervasive developmental disorders as defined in the most current edition of the Diagnostic and Statistical Manual of Mental Disorders.

Beech Street Network is the national network partnered with the Endeavor Providence network. Although all Beech Street providers are part of the Endeavor Providence network, not all Beech Street providers are loaded into the Endeavor Providence network system at this time. Members searching for a particular provider who is not listed in the Endeavor Providence network should check the Beech Street network as well.

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

Chemical Dependency (including alcoholism) means a substance-related disorder, as defined by the current edition of the Diagnostic and Statistical Manual of Mental Disorders, except for those related to foods, tobacco or tobacco products.

Chemical Dependency Outpatient Treatment Program means a state-licensed program that provides an organized outpatient course of treatment, with services by appointment, for substance-related disorders.

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

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.

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

Custodial Care means care that helps a member conduct such common activities as bathing, eating, dressing or getting in and out of bed. It is care that can be provided by people without medical or paramedical skills. Custodial care also includes care that is primarily for the purpose of separating a member from others, or for preventing a member from harming himself or herself.

Day Treatment or **Partial Hospitalization** means an appropriately licensed mental health or chemical dependency facility providing no less than 4 hours of direct, structured treatment services per day.

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 rendered 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.

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

The domestic partner and subscriber

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

Effective Date means the 1st of the following month if an application is received on the 1st to 15th of a month, or the 1st of the second month if an application is received from the 16th to the last day of a month. For new dependents, effective date means the date of birth for a newborn child, the date of the adoption decree for an adopted child, and the date of placement for a child placed for adoption. For new spouses and domestic partners, and persons who qualify due to loss of minimum essential coverage, it means the 1st day of the month following the qualifying event.

Emergency Medical Condition means a medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson possessing an average knowledge of health and medicine could reasonably expect that failure to receive immediate medical attention would place the health of a member, or a fetus in the case of a pregnant woman, in serious jeopardy.

Emergency Medical Screening Examination means the medical history, examination, ancillary tests and medical determinations required to ascertain the nature and extent of an emergency medical condition.

Emergency Services means those healthcare items and services furnished in an emergency department of a hospital, all ancillary services routinely available to the emergency department to the extent they are required for the stabilization of a member, and within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required to stabilize a member.

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

Experimental or Investigational means services and supplies that:

a. 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
b. Lack reliable evidence demonstrating that they are effective in clinical diagnosis, evaluation, management or treatment of the condition
c. Are the subject of ongoing clinical trials
d. Require additional research before they can be classified as equally or more effective than conventional therapies

Genetic Information pertains to a member or his or her relative, and means information about genetic tests, a request for or receipt of genetic services, or participation in clinical research that includes genetic services. It also includes the manifestation of a disease or disorder in a member's relative.

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

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

Illness means a disease or bodily disorder that results in a covered expense.

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 or Delta Dental to provide care to members.

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 providers in Alaska other than a facility is the lesser of billed charges or the 90th percentile of fees commonly charged for a given procedure in a given area, based on a national database.

Charges for services by an out-of-network provider outside of Alaska other than a facility will be paid at the out-of-network benefit level, and the MPA is the lesser of supplemental provider fee arrangements Moda Health may have in place and the 80th percentile of fees commonly charged for a given procedure in a given area, based on a national database.

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

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

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

MPA for emergency services received out-of-network is the greatest of the median in-network rate, the maximum amount as calculated according to this definition for out-of-network providers and the Medicare allowable amount.

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

When using an out-of-network provider, any amount above the MPA is the member's responsibility.

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 is not a condition.

Medically Necessary means those services and supplies that are required for diagnosis or treatment of a medical condition and are:

a. Appropriate and consistent with the symptoms or diagnosis of a member's condition
b. Established as the standard treatment by the medical community in the service area in which they are received
c. Not primarily for the convenience of a member or a provider
d. The least costly of the alternative supplies or levels of service that can be safely provided to a member. For example, care rendered in a hospital inpatient setting is not medically necessary if it could have been provided in a less expensive setting, such as a skilled nursing facility or by a nurse in the member's home, without harm to the member.

Medically necessary care does not include custodial care.

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. More information regarding medical necessity can be found in the General Exclusions (Section 7).

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

Mental Health refers to benefits, facilities, programs, levels of care and services related to the assessment and treatment of mental illness, as defined in the policy.

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

Mental Illness is an Axis I diagnosis listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders.

Moda Health refers to Moda Health Plan, Inc.

Moda Health Behavioral Health provides specialty services for managing mental health and chemical dependency benefits to help members access care in the right place and contain costs.

Network means a group of providers who contract to provide healthcare to members. Such groups are called Preferred Provider Organizations (PPOs), and provide in-network services in their specific service areas. Covered medical expenses will be paid at a higher rate when an in-network provider is used (see section 2.2).

Out-of-Network refers to providers that are not contracted under Moda Health or Delta Dental to provide benefits to members.

Outpatient Surgery means surgery that does not require an inpatient admission or overnight stay.

The **Plan** is the individual healthcare insurance 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 the application, this document, and any declaration pages, addendums, appendices, amendments, endorsements and riders.

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

Prior Authorization or **Prior Authorized** refers to obtaining approval by Moda Health prior to the date of service. A complete list of services and medications that require prior authorization is available on myModa or by contacting Customer Service. Failure to obtain required authorization may result in denial of benefits or a penalty (see section 3.1).

Professional Provider means an autism service provider as defined above or any state-licensed or state-certified healthcare professionals, when providing medically necessary services within the scope of their license or certification. In all cases, the services must be covered under the Plan to be eligible for benefits. Examples of professional providers include:

a. Acupuncturist
b. Certified community health aide, but only for performing well-baby exams
c. Chiropractor
d. Dentist (doctor of medical dentistry or doctor of dental surgery)
e. Direct-entry midwife
f. Mental health provider as defined above
g. Naturopath
h. Nurse (advanced nurse practitioner including one certified as a midwife, and a registered nurse or licensed practical nurse providing services upon the written referral of a physician and for which nurses customarily bill patients)
i. Optometrist
j. Physician (doctor of medicine or osteopathy)
k. Physician assistant
l. Podiatrist
m. Physical, occupational, or speech therapist, but only for rehabilitative or habilitative services provided upon the written referral of a physician

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

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 illness or chemical dependency. Residential program does not include any program that provides less than 4 hours per day of direct treatment services.

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

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

Urgent Care means immediate, short-term medical care provided by an urgent or immediate 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.

SECTION 6. BENEFIT DESCRIPTION

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. Payment of covered expenses is always limited to the maximum plan allowance. Some benefits have day or dollar limits, which are noted in the "Details" column in the Schedule of Benefits (section 2.2).

Many services require prior authorization (see Exhibit A). A complete list is available on myModa or by contacting Customer Service. Failure to obtain required prior authorization may result in denial of benefits or a penalty (see section 3.1).

5
6

6.1 MEMBERSHIP CARD

After enrolling, members will receive identification cards that will include the identification number. Members will need to present the card each time they receive services. Members may go to myModa or contact Customer Service for replacement of a lost identification card.

6.2 WHEN BENEFITS ARE AVAILABLE

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

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

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

6.3 EMERGENCY CARE

Members are covered for treatment of emergency medical conditions worldwide. A member who believes he or she has a medical emergency should call 911 or seek care from the nearest appropriate provider, such as a physician's office or clinic, urgent care facility or emergency room. All emergency services will be reimbursed at the in-network benefit level. However, out-of-network providers may bill members for charges in excess of the maximum plan allowance.

Prior authorization is not required for emergency services, including emergency medical screening exams or treatment to stabilize an emergency medical condition, whether in-network or out-of-network.

If a member's condition requires hospitalization in an out-of-network facility outside of Alaska or one located within 50 miles of an in-network hospital in Alaska, 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 the in-network benefit level for care beyond the date it is determined the member can be safely transferred.

The in-network benefit level is not available if a member goes to an Alaska Regional hospital that is within 50 miles of an Endeavor Providence hospital in Alaska or an out-of-network provider outside of Alaska for care other than emergency medical care. The following are not emergency medical conditions and are not eligible for the in-network benefit level if provided outside of Alaska (this is not inclusive of all such services):

a. Preventive services
b. Diagnostic work-ups for chronic conditions
c. Elective surgery and/or hospitalization

6.4 HOSPITAL & RESIDENTIAL FACILITY CARE

A hospital is a facility that is licensed as an acute care hospital and that provides inpatient surgical and medical care to members who are acutely ill. Its services must be under the supervision of a staff of licensed physicians and must include 24-hour-a-day nursing service by registered nurses. Facilities that are primarily rest, old age or convalescent homes are not considered hospitals.

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 mandated by law.

Hospitalization must be directed by a physician and must be medically necessary. All inpatient and residential stays require prior authorization (see section 3.1.1). Failure to obtain required prior authorization will result in denial of benefits or a penalty.

6.4.1 Emergency Room Care

Medically necessary emergency room care is covered. See section 6.3 for more information.

6.4.2 Pre-admission Testing

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

6.4.3 Hospital Benefits

The Plan allows benefits for an unlimited number of days for acute hospital care. Covered expenses consist of the following:

a. **Hospital room.** The actual daily charge
b. **Isolation care.** When necessary, based on generally recognized medical standards, to protect other patients from contagion or to protect a member from contracting the illness of another person
c. **Intensive care unit.** Whether a unit in a particular hospital qualifies as an intensive care unit is determined using generally recognized standards
d. **Facility charges.** For surgery performed in a hospital outpatient department
e. **Other hospital services and supplies.** Those necessary for treatment and ordinarily furnished by a hospital

f. **Routine nursery care.** Including one in-nursery physician's visit of a well-newborn infant while the mother is confined in the hospital and receiving maternity benefits under the Plan. The deductible is waived for routine nursery care.

Coverage for take-home prescription drugs following a period of hospitalization will be limited to a 3-day supply at the same benefit level as for hospitalization.

6.4.4 Inpatient Rehabilitative and Chronic Pain Care

Covered rehabilitative care expenses for inpatient services delivered in a hospital or other inpatient facility that specializes in such care are subject to an annual limit, except for treatment of autism spectrum disorders in members under age 21.

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

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

For members under age 7, or under age 21 with autism spectrum disorders, neurodevelopmental therapy to restore and improve function and maintenance therapy to prevent significant deterioration in the member's condition or function are covered.

6.4.5 Skilled Nursing Facility Care

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

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.

The Plan will not pay charges related to an admission to a skilled nursing facility before the member was covered by this policy or for a stay where care is provided principally for:

a. Senile deterioration
b. Alzheimer's disease
c. Mental deficiency or intellectual disability
d. Mental illness

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

6.4.6 Residential Mental Health and Chemical Dependency Treatment Programs

All-inclusive daily charges for room and treatment services, including day treatment and partial hospitalization, by a treatment program that meets the definition in the Plan are covered.

6.4.7 Chemical Dependency Detoxification Program

All-inclusive daily charges for room and treatment services by a treatment program that meets the definition in the Plan are covered.

6.5 AMBULATORY SERVICES

Many ambulatory services require prior authorization (see section 3.1.2).

6.5.1 Outpatient Surgery

The Plan covers operating rooms and recovery rooms, surgical supplies and other services ordinarily provided by a hospital or surgical center.

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.

6.5.2 Outpatient Rehabilitation and Habilitation and Chronic Pain Care

Rehabilitative and habilitative services provided by a licensed physical, occupational or speech therapist, physician, chiropractor or other professional provider licensed to provide such services, including physical, speech, occupational and massage therapy and cardiac and pulmonary rehabilitation, are subject to an annual limit, except for care for autism spectrum disorders provided for members under age 21. Each session or type of therapy by a different professional provider is counted as one visit, and multiple therapy sessions by the same provider in one day are counted as one visit.

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

For members under age 7, or under age 21 with autism spectrum disorders, neurodevelopmental therapy to restore and improve function and maintenance therapy to prevent significant deterioration in the member's condition or function are covered.

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

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

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

6.5.3 Infusion Therapy

The Plan covers infusion therapy services and supplies when prior authorized and ordered by a professional provider as a part of an infusion therapy regimen. . See section 6.9.6 for self-administered infusion therapy.

Infusion therapy benefits are limited to the following:

a. aerosolized pentamidine
b. intravenous drug therapy
c. total parenteral nutrition

d. hydration therapy
e. intravenous/subcutaneous pain management
f. terbutaline infusion therapy
g. SynchroMed pump management
h. IV bolus/push medications
i. blood product administration

In addition, covered expenses include only the following medically necessary services and supplies:

a. solutions, medications, and pharmaceutical additives
b. pharmacy compounding and dispensing services
c. durable medical equipment for the infusion therapy
d. ancillary medical supplies
e. nursing services associated with
    i. patient and/or alternative care giver training
    ii. visits necessary to monitor intravenous therapy regimen
    iii. emergency services
    iv. administration of therapy
f. collection, analysis, and reporting of the results of laboratory testing services required to monitor response to therapy

6.5.4 Diagnostic X-rays and Laboratory Tests

The Plan covers diagnostic x-rays and laboratory tests related to treatment of a medical condition.

6.5.5 Radium, Radioisotopic, X-ray Therapy, and Kidney Dialysis

Covered expenses include:

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

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

6.5.6 Imaging Procedures

The Plan covers all standard imaging procedures related to treatment of a medical condition. The following advanced imaging services require prior authorization (see section 3.1):

a. Magnetic resonance imaging (MRI) or magnetic resonance angiography (MRA)
b. Computerized axial tomography (CT or CAT) or computed tomography angiogram (CTA)
c. Positron emission tomography (PET)
d. Single photon emission computed tomography (SPECT)
e. Nuclear cardiology studies

6.5.7 Outpatient Chemical Dependency Services

Services for assessment and treatment of chemical dependency in an outpatient treatment program are covered. Behavioral Health Customer Service can help members locate in-network providers and understand the chemical dependency benefits.

6.5.8 Clinical Trials

Routine costs for the care of a member who is enrolled in an approved clinical trial as defined in federal or state laws related to cancer or other life-threatening condition, including leukemia, lymphoma, and bone marrow stem cell disorders are covered. Such costs will be subject to the applicable cost sharing if provided in the absence of a clinical trial. Moda Health is not liable for any adverse effects of a clinical trial.

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

The following costs are covered:

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

The Plan does not cover:

a. A drug or device associated with the clinical trial that has not been approved by the FDA
b. Housing, companion expenses, or other nonclinical expenses associated with the clinical trial
c. An item or service provided solely to satisfy data collection and analysis and not used in the clinical management of the member
d. An item or service excluded from coverage in Section 7
e. An item or service paid for or customarily paid for through grants or other funding

6.6 PROFESSIONAL PROVIDER SERVICES

6.6.1 Preventive Healthcare

As required under the Affordable Care Act, certain services will be covered at no cost to the member when performed by an in-network provider (see section 2.2 for benefits paid at the out-of-network level):

a. Evidence-based services rated A or B by the United States Preventive Services Taskforce
b. Immunizations recommended by the Advisory Committee on Immunization Practices of the Center for Disease Control and Prevention (ACIP)
c. Preventive care and screenings recommended by the Health Resources and Services Administration for infants, children, adolescents, and women

If one of these organizations adopts a new or revised recommendation, Moda Health 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. Other preventive services are subject to the applicable cost sharing when not prohibited by the federal law. Some frequently used preventive healthcare services covered by the Plan are:

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

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

b. Newborn and Infant Hearing Screening. An initial newborn or infant hearing screening performed by a professional provider within 30 days after the child's birth. If the initial screening determines that the child may have a hearing impairment, additional diagnostic hearing tests up to age 24 months are covered.

c. Routine Vision Screening. Screening to detect amblyopia, strabismus and defects in visual acuity in children age 3 to 5.

d. Periodic Health Exams. Covered according to the following schedule:

   i. Newborn: One hospital visit
   ii. Age 2 to 4: 3 exams
   iii. Age 5 and above: One exam every year

   An exam to rule out a diagnosis of illness based on family history is eligible for benefits as a periodic health exam based on the above schedule.

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

e. 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 work environment are not covered.

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

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

g. Routine Prostate Rectal Exam & Prostate Specific Antigen (PSA) Test. These services are subject to the standard cost sharing. For men age 40 and over, the Plan covers one rectal examination and one PSA test every year. The Plan also covers one rectal examination and one PSA test every year for men between the ages of 35 and 40 who are African-American or have a family history of prostate cancer.

h. Colorectal Cancer Screening. The following services, including related charges, for members age 50 and over:

   i. One routine flexible sigmoidoscopy and pre-surgical exam or consultation every 5 years
   ii. One routine colonoscopy, including polyp removal, and pre-surgical exam or consultation every 10 years
   iii. One CT colonography (virtual colonoscopy) every 5 years
   iv. One double contrast barium enema every 5 years
   v. One take-home package for fecal occult blood test or fecal immunochemical test every year

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

6.6.2 Contraception

All FDA approved contraceptive methods and counseling, including related office visits, are covered when prescribed by a professional provider. Women's contraception, when delivered by an in-network provider and utilizing the most medically appropriate cost effective option (e.g., generic instead of brand name), will be covered with no cost sharing.

6.6.3 Home, Office or Hospital Visits (including Urgent Care visits)

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

6.1
6.2
6.2.1
6.2.2
6.2.3

6.6.4 Electronic Visits

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

6.6.5 Diabetes Self Management Programs

The Plan covers outpatient self-management training or education and medical nutrition therapy when prescribed by a professional provider for the treatment of diabetes. Additional information regarding coverage for diabetic related supplies is in sections 6.7.8 and 6.9.

6.6.6 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 home self-care, or through oral use of a prescription drug, administrative services for therapeutic

injections are not covered. Additional information is in section 6.8.1 and 6.9. Vitamin and mineral injections are not covered unless medically necessary for treatment of a specific medical condition.

6.6.7 Surgery

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

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

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

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

6.6.8 Reconstructive Surgery Following a Mastectomy

The Plan covers reconstructive surgery following a covered 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 of the mastectomy, including lymphedemas
e. Inpatient care related to the mastectomy and post-mastectomy services

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

6.6.9 Cosmetic and Reconstructive Surgery

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

Cosmetic surgery is not covered. Reconstructive procedures that are partially cosmetic in nature may be covered if the procedure is determined to be medically necessary. Coverage is available for surgical repair of congenital deformities if prior authorized and medically necessary. All reconstructive procedures must be medically necessary and prior authorized or benefits will not be paid.

Treatment for complications related to a surgery performed to correct a functional disorder is covered when medically necessary. Treatment for complications related to a surgery that does not correct a functional disorder is excluded.

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 6.6.8.

6.6.10 Cochlear Implants
Cochlear implants are covered when medically necessary and prior authorized.

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

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

a. Diagnostic
   i. Diagnostic exams once every 6 months
   iii. Full series or panoramic X-rays once every 5 years
   iv. Periapical X-rays not included in the full series for diagnosis
   v. Supplementary bitewing X-rays once every 6 months
   vi. An occlusal intraoral X-ray every 2 years
   vii. Cephalometric films
   ix. Diagnostic casts other than those under the orthodontic benefits
   x. Oral and facial photographic images on a case-by-case basis

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

b. Preventive
   i. Prophylaxis once every 6 months (may be eligible for additional cleanings if pregnant or diabetic)
   ii. Topical fluoride treatment once every 6 months
   iii. Sealant once every 3 years on unrestored permanent molars
   v. Space maintainers, including re-cementation

c. Minor Restorative Services
   i. Amalgam fillings on posterior teeth and composite fillings on anterior teeth
   ii. Re-cementation of inlays or crowns
   iii. Prefabricated stainless steel crowns for under age 15 one per tooth every 5 years
   iv. Protective restoration and pin retention per tooth

d. Endodontic
   i. Therapeutic pulpotomy if no root canal therapy is performed within 45 days of a pulpotomy
   ii. Partial pulpotomy for apexogenesis on permanent teeth if no root canal therapy performed within 45 days of a pulpotomy
   iii. Pulpal therapy (resorbable filling) for primary incisor teeth up to age 6 and for primary molars and cuspids up to age 11 once per tooth per lifetime
   iv. Root canal therapy
   v. Retreatment of previous root canal therapy (at least 24 months after original root canal therapy)
   vi. Apexification or recalcification
   vii. Pulpal regeneration

viii. Apicoectomy and periradicular surgery
ix. Root amputation
x. Hemisection

Other endodontic services not mentioned in this section are not covered such as endodontic implant, intentional replantation and canal preparation.

e. Periodontic
   i. Periodontal scaling and root planing once per quadrant every 24 months
   ii. Periodontal maintenance limited to 4 in 12 months combined with prophylaxis
   iii. Full mouth debridement limited to once in a 3-year period
   iv. Gingivectomy or gingivoplasty
   v. Gingival flap procedure
   vi. Clinical crown lengthening
   vii. Osseous surgery
   viii. Pedicle soft tissue graft
   ix. Free soft tissue graft procedure (including donor site surgery)
   x. Subepithelial connective tissue graft procedures (including donor site surgery)

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

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

g. Major Restorative Services
   i. Inlays are limited to the benefit for a filling
   ii. Onlays and crowns once per tooth every 5 years
   iii. Crown buildup once per tooth every 5 years
   iv. Core buildup, including pins, on permanent teeth in conjunction with a crown
   v. Prefabricated post and core once per tooth every 5 years
   vi. Crown repair on a case by case basis

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

h. Prosthodontic
   i. Complete or partial dentures once per tooth site every 5 years
   ii. Dental implants when determined dentally necessary, at least 5 years after last cast restoration. If dental implants are not covered, the implant crown, bridge, denture or partial denture are covered subject to the Major Restorative or Prosthodontic benefit limits
   iii. Adjustment, repair, recementation or replacement of broken tooth for the denture
   iv. Rebase and reline once every 3 years (at least 6 months after the initial installation)
   v. Tissue conditioning

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

i. Orthodontia
There is a 2-year exclusion period for orthodontic services:
   i. Treatment of the primary, transitional, or adolescent dentition
   ii. Removable or fixed appliance therapy
   iii. Pre-treatment visit and periodic visits
   iv. Retention including removal of appliances, construction and replacement of retainers

At the initial placement, the Plan pays no more than 25% of the covered expense for the appliance and the balance will be made in equal payments over a maximum period of 29 months. The Plan's obligation to make payments for treatment will end when treatment stops for any reason prior to completion, or upon termination of eligibility.

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

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

6.6.13 Special Dental Care

Dental services for members age 19 and up are not covered, except for treatment of accidental injury to natural teeth. Natural teeth are teeth that grew/developed in the mouth. All the following are required to qualify for coverage:

a. The accidental injury must have been caused by a foreign object or was caused by acute trauma (e.g., a broken tooth resulting from biting and/or chewing is not an accidental injury)
b. Diagnosis is made within 6 months of the date of injury
c. Treatment is medically necessary and is provided by a physician or dentist while the member is covered by this policy

The Plan only covers treatment within 12 months of the date of injury. Covered treatment is limited to that which will restore teeth to a functional state. Implants and implant related services are not covered.

6.6.14 Facility Charges for Dental Procedures

General anesthesia services and related facility charges are covered in conjunction with a dental procedure performed in a hospital or ambulatory surgical center if medically necessary for members who are:

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

6.6.15 Alternative Care

Services such as office visits, lab and diagnostic x-rays and physical therapy services are not covered under this benefit. They are subject to the Plan's standard benefit for those services.

Spinal and Other Manipulations

Covered up to an annual visit limit for treatment of a medical condition.

Acupuncture
Covered up to an annual visit limit.

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

6.6.17 Podiatry Services
Covered for the diagnosis and treatment of a specific current problem. Routine podiatry services are not covered.

6.6.18 Mental Health
The Plan covers medically necessary outpatient services by a mental health provider as defined in Section 5. Behavioral Health Customer Service can help members locate in-network providers and understand the mental health benefits.

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

6.6.20 Applied Behavior Analysis
Medically necessary applied behavior analysis 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. Prior authorization and submission of an individualized treatment plan are required.

Applied behavior analysis does not include psychological testing, neuropsychology, psychotherapy, cognitive therapy, sex therapy, psychoanalysis, hypnotherapy or long term counseling as treatment modalities.

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, social counseling, music therapy, neurofeedback, chelation or hyperbaric chamber
c. Services provided under an individual education plan in accordance with the Individuals with Disabilities Education Act (20 USC 1400 et seq)
d. Services provided by the Department of Social and Health Services, other than employee benefit plans offered by the Department

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

6.7 Other Services

6.7.1 Ambulance Transportation
Licensed surface (ground or water) and air ambulance are covered for medically necessary transport to the nearest facility that has the capability to provide the necessary treatment.

Medically necessary services and supplies provided by the ambulance are also covered. This benefit only covers the member that requires transportation.

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

6.7.2 Commercial Transportation

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

6.7.3 Hospice Care

a. Definitions

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

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

Hospice 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.

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

b. Hospice Home Care

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

i. Registered or licensed practical nurse
ii. Physical, occupational or speech therapist
iii. Certified respiratory therapist
iv. Home health aide
v. Licensed social worker

c. Hospice Inpatient Care

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

d. Respite Care

Respite care means care for a period of time to relieve persons residing with and caring for a member in hospice from their duties. Providing care to allow a caregiver to return to work does not qualify as respite care.

The Plan covers respite care provided to a member who requires continuous assistance when arranged by the attending professional provider and prior authorized by Moda Health. Benefits

are limited to an hourly maximum for services provided in the most appropriate setting. The services and charges of a non-professional provider may be covered for respite care if approval is given by Moda Health in advance.

e. Exclusions
In addition to exclusions listed in Section 7, the following are not covered:

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

6.7.4 Maternity Care

Pregnancy care, childbirth and related conditions, including voluntary abortions, are covered when rendered by a professional provider. The Plan covers facility charges for maternity care when provided at a covered facility, including a birthing center.

Home birth expenses are not covered other than medically necessary supplies and fees billed by a professional provider. Additional information regarding home birth exclusions is in Section 7. 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.

Special Right Upon Childbirth (Newborns' and Mothers' Health Protection Act) Benefits for any hospital length of stay in connection with childbirth will not be restricted to less than 48 hours following a normal vaginal delivery or 96 hours following a 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.

6.7.5 Breastfeeding Support

Comprehensive lactation support and counseling is covered during pregnancy and/or the postpartum 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.

6.7.6 Transplants

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

a. Definitions.
Exclusive transplant network facility means a healthcare facility with which Moda Health has contracted or arranged to provide facility transplant services.

Transplant means a procedure or series of procedures by which:

i. 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)
ii. tissue is removed from one's body and later re-introduced 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.

b. Covered Benefits. Benefits for transplants are limited as follows:
   i. Transplant procedures must be performed at an exclusive transplant network facility. If an exclusive transplant facility cannot provide the necessary type of transplant, Moda Health will prior authorize services at an alternative transplant facility.
   ii. If the recipient or self-donor is enrolled in this policy, donor costs related to a covered transplant are covered. If the donor is enrolled in this policy and the recipient is not enrolled, the Plan will not pay any benefits toward donor costs. Expenses incurred by a donor not enrolled in the policy that result from complications and unforeseen effects of the donation are not covered. Donor costs paid under any other health coverage are not covered by this policy. "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 as well as any other necessary charges directly related to locating and procuring the organ.
   iii. Travel and housing expenses for the recipient and one caregiver, or 2 caregivers if the recipient is a minor, are covered up to a maximum per transplant when the recipient resides more than 50 miles from the exclusive transplant network facility unless the medical condition requires treatment at a closer transplant facility.
   iv. Professional provider transplant services are paid according to plan benefits for professional providers.
   v. 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 Medication benefit (section 6.9).
   vi. 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.

c. 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.

6.7.7 Home Healthcare

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

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

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

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

This benefit does not include home healthcare, home care services, and supplies provided as part of a hospice treatment plan. These are covered under sections 6.7 and 6.7.8.

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

6.7.8 Supplies, Appliances, and Durable Medical Equipment

Outpatient supplies, appliances and durable medical equipment, including related sales tax, are covered.

Supplies

Includes:

a. Medical supplies used in a professional provider's office
b. Application of a cast
c. Supplies related to a colostomy or mastectomy
d. Pumps and meters for diabetes

Prosthetics

The first extremity prosthesis after loss of a body part is covered, including artificial eyes and post-mastectomy bra and prosthetic. An additional prosthesis may be authorized if the attending physician provides documentation to Moda Health that a new prosthetic device is medically necessary because of changing fit or poor function. Testicular prostheses are not covered.

Appliances

Items, including orthopedic braces, used for performing or facilitating the performance of a particular bodily function. Foot orthotics are subject to a coverage limit when not related to diabetes. Within 90 days following cataract surgery, one conventional intraocular lens or one contact lens or eyeglasses is covered for each eye operated on. Other medical vision hardware is covered when medically necessary for treatment of corneal ulcer, bullous keratopathy, recurrent erosion of cornea, tear film insufficiency, aphakia, Sjogren's disease, congenital cataract, corneal abrasion and keratoconus.

The following are not covered: dental appliances and braces, supporting devices such as corsets, compression or therapeutic stockings except when such stockings are medically necessary, and hearing aids, eye glasses and contact lenses except as otherwise covered under the policy.

Orthopedic shoes

Covered if they are an integral part of a leg brace or if a professional provider has ordered that orthopedic shoes be individually designed for correction or support of a deformity. If such correction or support is accomplished by modification of a mass-produced shoe, then the covered expense is limited to the cost of the modification. The covered expense will not include the original cost of the shoe. Orthopedic shoes or modifications are not covered if they are solely for comfort or convenience.

Durable medical equipment

Equipment and related supplies that are used primarily to serve a medical purpose, are not generally useful to a member in the absence of a medical condition, are appropriate for use in the member's home and are designed to withstand repeated use. Examples of durable medical equipment include a wheelchair, a hospital-type bed, and oxygen.

The Plan covers the rental charge (not to exceed the purchase price) for durable medical equipment. Upon request, members must authorize any supplier furnishing durable medical

equipment to provide information related to the equipment order and any other records Moda Health requires to approve a claim payment.

Replacement or repair
Only covered if the appliance, prosthetic, equipment or durable medical equipment was not abused, was not used beyond its specifications and not used in a manner to void applicable warranties.

Exclusions
In addition to the exclusions listed in Section 7, 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. Wigs and toupees
c. Those used for education or environmental control (additional information regarding Supportive Environmental materials can be found in Section 7)
d. Therapeutic devices, except for transcutaneous nerve stimulators
e. Incontinence supplies

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

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

6.7.10 Hearing Exam and Hardware
Members must be examined by a physician before obtaining a hearing aid. The Plan covers the following expenses once in a 3-year period:

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

The following services and supplies are not covered:

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

Any expense paid in whole or in part by any other provision of the Plan

6.7.11 Pediatric Vision Services

The Plan covers one complete eye exam, one pair of standard eyeglass lenses and frames every year, or one pair of contact lenses in lieu of eyeglasses every year for members through the end of the month in which they reach age 19. Optional lenses and treatments limited to ultraviolet protective coating, blended segment lenses, intermediate vision lenses, progressive lenses, photochromic glass lenses, plastic photosensitive lenses, polarized lenses, anti-reflective (AR) coating, and hi-index lenses are covered.

Members may choose any licensed ophthalmologist or optometrist for these services, and glasses may also be provided by any licensed optician.

6.7.12 Adult Vision Care Services

The Plan pays for vision examinations and corrective lenses and frames for members over age 19. Vision care can be prescribed by a licensed ophthalmologist or licensed optometrist. Any licensed ophthalmologist, optician, or optometrist may be selected. Payment is based on the contracted fee for in-network providers and billed charges for out-of-network providers. By utilizing an in-network provider benefits will be maximized.

Covered services and supplies are:

a. One complete eye exam, including the charge for refraction
b. One pair of frames for corrective lenses
c. A pair of lenses is covered every year. Contact lenses are covered in lieu of eyeglasses.

Whether covered under the vision care benefit or the medical portion of the Plan, benefits are limited to one pair of contact lenses, disposable contacts, or one pair of eyeglasses every year.

In addition to the exclusions listed in Section 7, the following services and supplies are not covered:

a. Special procedures such as orthoptics and vision training
b. Charges for fashion eyewear features
c. Any extra charge for lenses with special purpose vision aids
d. Nonprescription lenses
e. Medical or surgical treatment of the eyes

6.8 MEDICATIONS

6.8.1 Medication Administered by Provider, Infusion Center or Home Infusion

A medication that is given by injection or infusion (intravenous administration) and is required to be administered in a provider's office, infusion center or home infusion is covered at the same benefit level as a supply. If the pharmaceutical is available in an oral dosage form, the Plan will not cover it in the form of an injectable medication unless it is medically necessary that the member use the injectable form. In addition, infusion and in-office injectables may require prior authorization by Moda Health or be subject to specific benefit limitations (more information is available on the Moda Health website). Self-administered medications are not covered under this benefit (see section 6.9).

6.9 PHARMACY PRESCRIPTION MEDICATION BENEFIT

6.9.1 Definitions

Brand Medications. A brand medication is sold under a trademark and protected name.

Brand Substitution. 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 will be responsible for the brand cost sharing plus the difference in cost between the generic and the brand medication.

Brand Tier Medications. Brand medications, including specialty brand medications, 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.

Formulary. A formulary is a listing of all prescription medications and their coverage under the prescription medication benefit. A prescription price check tool is available on myModa under the pharmacy tab. This online formulary tool provides coverage information, treatment options and price estimates.

Generic Medications. Generic medications have been determined by physicians and pharmacists to be therapeutically equivalent to the brand alternative and are 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.

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

Over the Counter (OTC) Medications. An over the counter medication is a medication that may be purchased without a professional provider's prescription. OTC designations for specific medications vary by state. Moda Health follows the federal designation of OTC medications.

Preferred Tier Medications. Preferred medications, including specialty preferred medications, have been found to be clinically effective at a favorable cost when compared to other medications in the same therapeutic class and/or category. Generic medications that have been identified as having no more favorable outcomes, from a clinical perspective, than other more cost effective generic medications may be included in this tier.

Preferred Medication List. The Moda Health Preferred Medication List is available on myModa. It provides information about the coverage of commonly prescribed medications and is not an all-inclusive list of covered products. Medications that are new to the market and newly FDA approved medications are subject to review and may be subject to additional coverage parameters, requirements, or limits.

The preferred medication list and the tiering of medications are subject to change and will be periodically updated. A prescription price check tool is available on myModa under the pharmacy tab. Members with any questions regarding coverage should contact Customer Service.

Moda Health bears no responsibility for any prescribing or dispensing decisions. These decisions are to be made by the professional provider and pharmacist using their professional judgment. Members should consult their professional providers about whether a medication from the

preferred list is appropriate for them. This list is not meant to replace a professional provider's judgment when making prescribing decisions.

Select Tier Medications. Select medications include those generic medications that represent the most cost effective option within their therapeutic category, as well as certain brand medications that have been identified as favorable from a clinical and cost effective perspective.

Self Administered Medications. Prescription medications labeled by the FDA for self administration, which can be safely administered by the member or the member's caregiver outside of a medically supervised setting (such as a hospital, physician office or infusion center) and that does not usually require administration by a licensed medical provider.

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

Value Tier Medications. Value medications include commonly prescribed products used to treat chronic medical conditions and preserve health. A list of value medications is available on myModa.

6.9.2 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
b. It is incurred while the member is eligible under the policy
c. The prescribed medication is not excluded

6.9.3 Covered Medication Supply

Includes the following:

a. A legend medication that is medically necessary for treatment of a medical condition
b. Compounded medications containing at least one covered medication as the main ingredient
c. Insulin and diabetic supplies including insulin syringes, needles and lancets, glucometers and test strips, and glucose tablets when accompanied by a valid prescription
d. Medications for treating tobacco dependence, including prescribed OTC nicotine patches, gum or lozenges from an in-network retail pharmacy available with no cost sharing as required under the Affordable Care Act
e. Select prescribed preventive medications required under the Affordable Care Act
f. Legend contraceptive medications and devices for birth control (section 6.6.2) and medical conditions covered under the policy
g. Select immunizations (section 6.6.1) and related administration fees are covered with no cost sharing at in-network retail pharmacies (e.g. influenza, pneumonia and shingles vaccines).
h. Inhalation spacer devices and peak flow meters

Certain prescription medications and/or quantities of prescription medications may require prior authorization (see section 3.1.3 and Exhibit A). Specialty tier and some other tier medications must be dispensed through an exclusive specialty pharmacy provider.

6.9.4 Mail Order Pharmacy

Members have the option of obtaining prescriptions for covered medications through an exclusive mail order pharmacy. A mail order pharmacy form can be obtained on myModa or by contacting Customer Service.

6.9.5 Specialty Services and Pharmacy

The member's pharmacist and other professional providers will advise a member if a prescription requires prior authorization or delivery by an exclusive specialty pharmacy. Specialty medications are often used to treat complex chronic health conditions. Because specialty treatments often require special handling techniques, careful administration and a unique ordering process, the Plan provides enhanced member services for these medications. Information about the clinical services and a list of eligible specialty medications is available on myModa or by contacting Customer Service. If a member does not purchase these medications at the exclusive specialty pharmacy, the expense will not be covered.

Specialty medications must be prior authorized. Some specialty prescriptions may have shorter day supply coverage limits. More information is available in Exhibit A, on myModa or by contacting Customer Service. 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.

6.9.6 Self Administered Medication

All self-administered medications are subject to the pharmacy prescription medication requirements of section 6.9. Self-administered specialty medications are subject to the same requirements as other specialty medications (section 6.9.5). For some specialty medications, members may be required to enroll in programs to ensure patient safety, proper drug use and/or reduce the cost of the medication.

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

6.9.7 Step Therapy

Step therapy requires members to try selected medications before proceeding to alternative treatments. Brand medications are available as shown in section 2.2 once members have tried and failed first line therapies.

6.9.8 Limitations

To ensure appropriate access to medications, the following limitations apply:

a. New FDA approved medications are subject to review and may be subject to additional coverage parameters, requirements, or limits established 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 dispensed when a generic equivalent is available, the member may be responsible for the difference in cost between the generic and brand medication. Expenses incurred due to brand substitution do not accrue to the out-of-pocket maximum
c. Select specialty medications that have been determined to have a high discontinuation rate or short durations of use may be limited to a 15-day supply
d. Medications with dosing intervals beyond the Plan's maximum day supply will be assessed an increased copayment consistent with the day supply
e. Claims for medications purchased outside of the United States and its territories will only be covered in emergency and urgent care situations

f. Early refill of medications for travel outside of the United States is subject to review. When allowed, is limited to once every 6 months

6.9.9 Exclusions

In addition to the exclusions listed in Section 7, 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 6.6.2 and for other devices in section 6.9.3
b. **Experimental or Investigational Medications.** Including any medication used for an experimental or investigational purpose, even if it is otherwise approved by the federal government or recognized as neither experimental nor investigative for other uses or health conditions, except as required in section 6.5.7.
c. **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.
d. **Hair Growth Medications.**
e. **Immunization Agents for Travel.**
f. **Institutional Medications.** To be taken by or administered to a member in whole or in part while the member is a patient in a hospital, sanitarium, rest home, skilled nursing facility, extended care facility, nursing home, or similar institution.
g. **Medication Administration.** A charge for administration or injection of a medication, except for select immunizations at in-network pharmacies.
h. **Medications Covered Under Another Benefit.** Such as medications covered under home health, medical, etc.
i. **Medications Not Approved by FDA.** Products not recognized or designated as FDA approved medications
j. **Non-Covered Condition.** A medication prescribed for purposes other than to treat a covered medical condition.
k. **Nutritional Supplements and Medical Foods.**
l. **Off-label Use.** Medications prescribed for or used for non-FDA approved indications, unless confirmed by other research studies, reference, compendium, or the federal government.
m. **Over the Counter (OTC) Medications** and prescription medications for which there is an OTC equivalent or alternative, except those treating tobacco dependence.
n. **Repackaged Medications.**
o. **Replacement Medications and/or Supplies.**
p. **Weight Loss Medications.**

6.10 ADDITIONAL ACCIDENT BENEFIT

Services and supplies received as treatment for an accidental injury that occurs while a member is covered will be at no cost share, subject to a maximum payment per incident, when completed within 90 days following the injury. Standard cost sharing applies after reaching dollar maximum or after 90 days, whichever comes first. Accidental injury does not include damage caused by routine or normal body movements such as stooping, twisting, bending or chewing and does not include any condition related to pregnancy or services provided as a result of over-exertion or muscle strains.

SECTION 7. 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 a provider. In addition, any direct complication or consequence that arises from these exclusions will not be covered.

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 due to an urgent or emergency medical condition

Charges Over the Maximum Plan Allowance

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

Cosmetic Procedures
Any procedure or medication requested for the purpose of improving or changing appearance without restoring impaired bodily function, including hormone treatment, rhinoplasty, breast augmentation, lipectomy, liposuction, and hair removal (including electrolysis and laser). Exceptions are provided for reconstructive surgery following a mastectomy (see section 6.6.8) and complications of reconstructive surgeries if medically necessary and not specifically excluded.

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 for assistance with activities of daily living, including but not limited to bathing, dressing, feeding, and administration of medications. Custodial care also includes care that is primarily for the purpose of separating a member from others, or for preventing a member from harming himself or herself.

Dental Examinations and Treatment; Orthodontia
Except as specifically provided for in sections 6.6.12 and 6.6.13

Enrichment Programs
Psychological or lifestyle enrichment programs including self-help programs, educational programs, assertiveness training, marathon group therapy, and sensitivity training, except as covered under section 6.6.21

Experimental or Investigational Procedures
Including expenses incidental to or incurred as a direct consequence of such procedures

Faith Healing

Family Planning
Surgery to reverse voluntary sterilization procedures (vasectomy or tubal ligation), and any men's contraceptive that can be legally dispensed without a prescription

Financial Counseling Services

Food Services
Meals on Wheels and similar programs

Guest Meals in a Hospital or Skilled Nursing Facility

Hearing Aids
Including fitting, provision, or replacement of internal and external hearing aids, and implantable hearing aids and the surgical procedure to implant them

Hippotherapy

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

Homemaker or Housekeeping Services

Homeopathy

Illegal Acts, Riot or Rebellion, War
Services and supplies for treatment of a medical condition caused by or arising out of a member's voluntary participation in a riot or arising directly from the member's illegal act. This includes any expense caused by, arising out of or related to declared or undeclared war, including civil war, martial law, insurrection, revolution, invasion, bombardment or any use of military force or usurped power by any government, military or other authority.

Infertility
All services and supplies for office visits, diagnosis and treatment of infertility, as well as the cause of infertility

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

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 mental illness

Missed Appointments

Naturopathy

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, which 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, which includes serious preventable events.

Nutritional Counseling
Except as provided for in section 6.6.16

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 6.7.8

Orthognathic Surgery
Including associated services and supplies

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

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 (e.g., diabetes):

a. Paring or cutting of benign hyperkeratotic lesion (e.g., corn or callus)
b. Trimming of dystrophic and non-dystrophic nails
c. Debridement of nails by any method

Self Administered Medications
Including oral and self injectable, when provided directly by a physician's office, facility or clinic instead of through the prescription medication benefit (section 6.9.6)

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

Services Not Provided

Services Otherwise Available
Including those services or supplies:

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 which has paid or is obligated to pay for such service or supply
c. for which no charge is made, 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 if the member is a veteran of the armed forces, in which case covered services and supplies furnished by the Veterans' Administration of the United States that are not service related are eligible for payment according to the terms of the Plan.

Services Provided or Ordered by a Relative
Other than services by a dental provider. Relatives, for the purpose of this exclusion, include a member or a spouse or domestic partner, child, sibling, or parent of a member or his or her spouse or domestic partner.

Services Provided by Volunteer Workers

Sexual Disorders
Services or supplies for treatment of sexual dysfunction or for sex change procedures and complications resulting from sex change procedures

Support Education
Including:

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

Supportive Environmental Materials
Including hand rails, 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.

Surgery to Alter Refractive Character of the Eye
Any procedure that alters the refractive character of the eye, the purpose of which is to cure or reduce myopia, hyperopia, or astigmatism. Includes reversals or revisions of any such procedures and any complications of these procedures

Taxes
Except sales tax related to durable medical equipment, prosthetics, orthotics and supplies

Telemedical Health Services
Including TeleMedicine, telephone visits or consultations and telephone psychotherapy, except for electronic visits covered in section 6.6.4

Telephones and Televisions in a Hospital or Skilled Nursing Facility

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

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 9.4.2)

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

Treatment in the Absence of Illness
Including individual or family counseling or treatment for marital, behavioral, financial, family, occupational or religious problems, treatment for “at risk” individuals in the absence of illness, or treatment of “normal” transitional response to stress

Treatment After Coverage Terminates
The only exception is if a member is hospitalized at the time of termination (see section 6.2), or for covered hearing aids ordered before coverage terminates and received within 90 days of the end date.

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 provider
e. Not the least costly of the alternative supplies or levels of service that can be safely provided to a member. For example, coverage is not allowed for an inpatient hospital stay when an appropriate level of treatment could be delivered in an outpatient setting such as an ambulatory surgery facility

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.

Treatment Prior to Enrollment

Vision Care
Including eye exams, the fitting, provision, or replacement of eyeglasses or contact lenses, and any charges for orthoptics, vitamin therapy, low vision therapy, eye exercises, or fundus photography, except as otherwise provided under the policy.

Vitamins and Minerals
Unless medically necessary for treatment of a specific medical condition and only if they bear the legend "Caution – Federal law prohibits dispensing without a prescription" and a dosage form of equal or greater strength of the medication is not available without a prescription under federal law. Applies whether the vitamin or mineral is oral, injectable, or transdermal

Wigs, Toupees, Hair Transplants

Work Related Conditions
Treatment of a medical condition arising out of or in the course of employment or self-employment for wages or profit, whether or not the expense is paid under any workers' compensation provision. This exclusion does not apply to owners, partners or executive officers if they are exempt from workers' compensation laws and their employer does not provide worker's compensation coverage to them.

SECTION 8. ELIGIBILITY & ENROLLMENT

To become a subscriber, a person must apply for individual or family coverage with the Health Insurance Marketplace during the open enrollment period or a special enrollment period. A subscriber must meet state and federal residency requirements.

Eligibility and enrollment, including premium tax credit and allocations or American Indian and Alaskan Native eligibility status, are administered by the Health Insurance Marketplace. Contact the Health Insurance Marketplace for information.

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

A subscriber's child who has sustained a disability rendering him or her physically or mentally incapable of self-support at even a sedentary level may be eligible for coverage even though he or she is over 26 years old. To be eligible, the child must be unmarried and principally dependent on the subscriber or the subscriber's parent for support and have had continuous medical coverage. The incapacity must have arisen, and the information below must be received, before the child's 26th birthday. Social Security Disability status does not guarantee coverage under this provision. Moda 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 at least 45 days before the child's 26th birthday:

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

Moda 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.

8.1 ENROLLING NEW DEPENDENTS

A subscriber may obtain coverage for newly acquired or newly eligible dependents by submitting an application (along with placement or adoption paperwork, if applicable) within 60 days of their eligibility.

8.2 OPEN ENROLLMENT PERIODS

Persons can apply for coverage during the open enrollment period. For 2016, open enrollment is from November 1, 2015 to January 31, 2016. These dates may be different for future years.

American Indians and Alaskan Natives, Medicaid participants and CHIP participants can apply for coverage in monthly enrollment periods.

8.3 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 through an employer but not as a result of non-payment of premium or rescission
b. Loss of coverage under Medicaid or a state child health plan
c. Obtaining new dependents through marriage, domestic partner registration, birth, adoption or placement for adoption or foster care, or a court order
d. Becoming a citizen, national or lawfully present individual
e. 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), or of a non-Health Insurance Marketplace entity providing enrollment assistance or conducting enrollment activities
f. Having adequate evidence that there is a violation of a material provision made by the Qualified Health Plan in which he or she is enrolled
g. Becoming eligible for advanced payments of the premium tax credit
h. Having a change in eligibility for cost sharing reductions
i. Moving permanently to a new location
j. Having other exceptional circumstances in accordance with guidelines issued by HHS and accepted by the Health Insurance Marketplace

8.4 WHEN COVERAGE BEGINS

Coverage begins for new applicants and their eligible dependents on the 1st day of the month following plan selection if loss of previous coverage was in the past. If loss of previous coverage is in the future, coverage begins on the 1st day of the month following the qualifying event.

Coverage for a newborn is effective on the date of the newborn's birth. Coverage for a child newly adopted or placed for adoption or as a foster child is effective on the date of adoption or placement. For new spouses or domestic partners and persons who qualified due to the loss of minimum essential coverage, coverage begins on the 1st of the month following plan selection.

The required premium or any applicable premium credit must be processed by the Health Insurance Marketplace for coverage to become effective.

8.5 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.

8.6 PREMIUMS

The current premium amount is shown either on the declaration page that comes with this policy, or any subsequent premium change notice. Members may contact the Health Insurance Marketplace regarding premium tax credits.

Premium payments are due monthly for continued coverage. Payments can be made by check, cashier's check, money order or prepaid debit card with a billing statement, or by electronic fund transfer (EFT). If a subscriber no longer wishes to pay by EFT, Moda 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 myModa.

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

8.6.1 When Payments are Due

All premium payments are due in advance. If payment is not received within the grace period (section 8.6.2), this policy will end. Coverage will end on the last day of the coverage period for which premiums were paid.

This policy is renewed each time a subscriber makes a timely premium payment.

8.6.2 Grace Period

Unless within 30 days before the premium due date Moda Health has delivered to the subscriber or mailed to the last address, as shown by its records, written notice of its intention not to renew this policy beyond the period for which the premium has been accepted, Moda Health will allow a 20-day grace period for payment after the premium due date, during which grace period the policy shall continue in force. Members who are eligible for tax credits and taking any portion as a prepaid subsidy will be allowed a 3 month grace period.

8.6.3 Reinstatement

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

8.6.4 Changes in Amount of Premiums

Moda Health can change the premium amount without notice when there is a change in the family composition or eligibility status. The premium change will take effect the first of the month following the event. When the subscriber moves into the next age bracket of the rate table, premiums will change on the renewal date. 45 days written notice will be provided before Moda Health renews this individual plan and makes changes to the premiums. When the new premium is paid, the payment confirms the subscriber's acceptance of the change.

8.6.5 Segregation of Premium for Abortion Services

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

charge is built into the premium and is not billed separately, Moda Health allocates the funds as required by law.

8.7 WHEN COVERAGE ENDS

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

a. Subscriber is no longer eligible for coverage through the Health Insurance Marketplace
b. Loss of dependent eligibility
c. Non-payment of premium
d. Rescission as described in section 8.8
e. Termination of the health benefit plan option
f. Moda Health's decertification to offer plans through the Health Insurance Marketplace
g. Subscriber terminates his or her coverage after 10-day advanced notice or changes health benefit plan during an open enrollment or special enrollment period

8.8 RESCISSION

Moda Health may rescind a member's coverage back to the effective date, or deny claims at any time, for fraud or intentional material misrepresentation, which 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 as liquidated damages, and the member shall be responsible for the full balance of any benefits paid. A member will be notified of a rescission 30 days prior to cancellation of coverage.

8.9 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.

SECTION 9. CLAIMS ADMINISTRATION & PAYMENT

9
9.1 SUBMISSION AND PAYMENT OF CLAIMS

9.1.1 Notice of Claim

Written notice of claim must be given to Moda Health as soon as reasonably possible after the occurrence or commencement of a loss covered by the policy. In no event, except absence of legal capacity, is a claim valid if submitted later than 15 months from the date the expense was incurred. Notice may be given by or on behalf of a member to Moda Health at P.O. Box 40384, Portland, Oregon 97240.

Moda Health does not require members to use a specific claim form. Information on how members can submit notice of a claim when the provider does not submit a claim form on their behalf is found in sections 10.1.2-10.1.5.

A provider may collect any applicable copayments at the time of service. An in-network provider cannot require advance payment of deductible and coinsurance amounts, but must bill Moda Health first.

9.1.2 Hospital and Professional Provider Claims

A member who is hospitalized or visits a professional provider must present his or her 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

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.

The same procedure should be followed with bills for hospital or professional provider care received outside the United States.

9.1.3 Ambulance and Commercial Transportation Claims

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

9.1.4 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 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 myModa.

9.1.5 Payment of Claims

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

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

9.1.6 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 myModa. Moda Health may pay claims, deny them, or accumulate them toward satisfying the 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 9.1.1.

9.1.7 Claim Inquiries

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

9.1.8 Time Frames for Processing Claims

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

If additional information is needed to complete processing of the claim, a notice will be sent describing the information needed, and the party responsible for providing the additional information will have 45 days to submit it. Once the additional information is received, processing of the claim will be completed within 15 days of receipt of the information or 30

days of the original receipt of the claim. If a claim is not completed timely, interest of 15% annually will accrue until processing of the claim is complete. Submission of information necessary to process a claim is also subject to the Plan's claim submission period explained in section 9.1.1.

9.1.9 Time Frames for Processing Prior Authorizations and Utilization Review

Any utilization review decision will be made within 72 hours after receipt of the request for prior authorization of nonemergency situations. For emergency situations, utilization review decisions for care following emergency services will be made as soon as is practicable but in any event no later than 24 hours after receiving the request for prior authorization or for coverage determination.

Any utilization review to deny, reduce, or terminate a health care benefit or to deny payment for a medical service because that service is not medically necessary shall be made by a Moda Health employee or agent who is a state-licensed health care provider.

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

9.2 COMPLAINTS, APPEALS AND EXTERNAL REVIEW

9.2.1 Definitions

For purposes of section 10.2, the following definitions apply:

Adverse Benefit Determination means a written notice from Moda Health, in the form of a letter or an Explanation of Benefits (EOB), of any of the following: denial of initial eligibility (this notice will come from the Health Insurance Marketplace) or rescission of coverage; or a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including one based on a determination of a person's eligibility to be covered by this policy and one resulting from the application of any pre-existing condition exclusion or utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not necessary and customary by the standards of generally accepted practice for the prevention or treatment of disease or accidental injury. A **Final Internal Adverse Benefit Determination** is an adverse benefit determination that has been upheld by Moda Health at the completion of the internal appeal process or with respect to which the internal appeal process has been exhausted.

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

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

Claim Involving Urgent Care means any claim for medical care or treatment in which the application of the regular time period to review a denial of a pre-service claim could seriously jeopardize a member's life or health or ability to regain maximum function, or, in the opinion

of a professional provider with knowledge of a member's medical condition, would subject the member to severe pain that cannot be adequately managed without the requested care or treatment.

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

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

Pre-service claim means any claim for a benefit under the Plan for care or services that require prior authorization.

Utilization review means a system of reviewing the medical necessity, appropriateness, or quality of medical care services and supplies using specified guidelines, including preadmission certification, the application of practice guidelines, continued stay review, discharge planning, prior authorization of ambulatory procedures, and retrospective review. 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.

9.2.2 Time Limit for Submitting Appeals

Members have **180 days** from the date of an adverse benefit determination to submit a written appeal. If an appeal is not submitted within this timeframe, the right to the appeal process will be lost.

The timelines addressed in section 10.2 do not apply when the member does not reasonably cooperate, or circumstances beyond the control of either party prevents that party from complying with the standards set (but only if the party who is unable to comply gives notice of the specific circumstances to the other party as soon as possible when the circumstances arise).

9.2.3 Appeals

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

Appeals of other adverse benefit determinations are administered by Moda Health. 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. Otherwise, an appeal must be submitted in writing. If necessary, Customer Service can provide assistance filing an appeal. The member may review the claim file and present evidence and testimony as part of the appeal process, and may appoint a representative to act on his or her behalf. Moda Health will acknowledge receipt of a written appeal within 7 days and conduct an investigation by persons who are not involved in the initial determination.

An appeal related to an urgent care claim will be entitled to expedited review upon request. An expedited review will be completed no later than 72 hours after receipt of the appeal by Moda Health, unless the member fails to provide sufficient information for Moda Health to make a decision. In this case, Moda Health will notify the member within 24 hours of receipt of the appeal of the specific information necessary to make a decision. The member will have 48 hours to provide the specified information. The investigation of an urgent care claim will be

completed no later than 48 hours following the earlier of (a) Moda Health's receipt of the specified information, or (b) the end of the period provided to submit the specified additional information.

Other investigations will be completed as follows:

a. Pre-service claim appeal within 15 calendar days
b. Post-service utilization review appeal within 18 business days
c. Post-service claim appeal not involving utilization review within 30 calendar days

Moda Health will provide for a written decision by a Moda Health employee or agent who holds the same professional license as the healthcare provider who is treating the member. If new or additional evidence or rationale is used by Moda Health in connection with the claim, it will be provided to the member, in advance and free of charge, before any final internal adverse benefit determination. The member may respond to this information before Moda Health's determination is finalized. Moda Health will send a written notice of the decision to the member, including the basis for the decision, and if applicable, information on the right to external review.

9.2.4 Appeals on Ongoing Care

If reducing or terminating an ongoing course of treatment before the end of the approved period of time or number of treatments, Moda Health will notify the member in advance and provide information about the right to appeal. Moda Health will provide continued coverage pending the outcome of an appeal. If the decision is upheld, the member is responsible for the cost of coverage received during the review period.

9.2.5 External Review

After exhausting the appeal process described in section 9.2.3, unless such requirement is waived by the Plan or waived because Moda Health fails to meet the internal timeline for review or to provide all of the information and notices required under federal law for appeals, members may request external review of an adverse benefit determination or final internal adverse benefit determination that involves medical judgment or rescission but does not include disputes about eligibility to participate in the Plan except for those related to rescissions. The request for external review must be in writing no more than 4 months after receipt of the final internal adverse benefit determination.

Moda Health will send a written notice to the member within 6 business days of receipt if the request is incomplete or ineligible for external review. Otherwise, the independent review organization will provide a written notice of the final external review decision within 45 days after its receipt of the request. For claims involving urgent care, the independent review organization will expedite the review and provide notice within 72 hours after its receipt of the request. The decision of the independent review organization is binding, except to the extent other remedies are available to the member under state or federal law.

9.2.6 Complaints

Moda Health will investigate complaints regarding the following issues when submitted in writing within 180 days from the date of the claim:

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

Investigation of a complaint will be completed within 30 days. If additional time is needed Moda Health will notify the member and have an additional 15 days to make a decision.

9.2.7 Additional Member Rights

Members may contact the Employee Benefits Security Administration at 866-444-3272 for questions about their appeal rights or for assistance.

Assistance may also be obtained from the Alaska Division of Insurance:

Phone: 907-269-7900 or toll free 800-467-8728
Mail: Division of Insurance
Consumer Services Section
550 West 7th Avenue, Suite 1560
Anchorage, AK 99501
email: insurance@alaska.gov
Internet: www.commerce.state.ak.us/dnn/ins/Consumers/FileaConsumerComplaint.aspx

9.3 CONTINUITY OF CARE

If a member is being actively treated by an in-network provider at the time the professional provider's written agreement with the PPO network terminates, the member may continue to be treated by that professional provider for a limited period of time. During this time, Moda Health will consider the professional provider to still have an agreement with the PPO network only while this policy remains in effect and for the period that is the longest of the following:

a. the end of the current policy year
b. up to 90 days after the termination date, if the event triggering the right to continuing treatment is part of an ongoing course of treatment
c. through completion of postpartum care, if the member is pregnant on the date of termination
d. until the end of the medically necessary treatment for the medical condition if the member has a terminal medical condition. In this paragraph, "terminal" means a life expectancy of less than one year

9.4 BENEFITS AVAILABLE FROM OTHER SOURCES

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

9.4.1 Coordination of Benefits (COB)

This provision applies when a member has healthcare coverage under more than one plan. A complete explanation of COB is in Section 10.

9.4.2 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. The policy does not cover benefits for which a third party may be legally liable. Because recovery from a third party may be difficult and take a long time, as a service to the member Moda Health will pay a member's expenses based on the understanding and agreement that Moda Health is entitled to be reimbursed in full from any recovery the member may receive for any benefits paid that are or may be recoverable from a third party or other source no matter how the recovery is characterized.

The member agrees that Moda Health has the rights described in section 10.4.2. 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.

9.4.2.1 Definitions

For purposes of section 9.4.2, the following definitions apply:

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

Recovery Funds means any amount recovered from a third party.

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

Third Party Claim means any claim, lawsuit, settlement, award, verdict, judgment, arbitration decision or other action against a third party (or any right to such an action) by or on behalf of a member, regardless of how the claims, damages or recovery funds are characterized. (For example, a member who has received payment of medical expenses from Moda Health 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 section 9.4.2.)

9.4.2.2 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.

9.4.2.3 Right of Recovery

In addition to its subrogation rights, Moda Health may, at its option, require a member, and his or her 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 medical condition.

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

c. If Moda Health requires the member and his or her attorney to protect its recovery rights under this section, then the member may subtract from the money to be paid back to Moda Health a proportionate share of reasonable attorney fees as an expense

for collecting from the other party.

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

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

9.4.2.5 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 agreement is properly signed and returned
   ii. Providing any information to Moda Health relevant to the application of the provisions of section 9.4.2, 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 his or her 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 Moda Health, 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 9.4.2.

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 9.4.2.

f. Section 9.4.2 applies to any member for whom advance payment of benefits is made by Moda Health 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 a medical condition after obtaining a settlement or recovery from a third party, Moda Health 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.

9.5 MEDICARE

The Plan coordinates benefits with Medicare Part A or B as required under federal government rules and regulations. To the extent permitted by law, the Plan will not pay for any part of a covered expense to the extent the expense is actually paid or would have been paid under Medicare Part A or B had the member properly enrolled in Medicare and applied for benefits. 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 physicians and providers who have opted out of Medicare participation.

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

SECTION 10. COORDINATION OF BENEFITS

Coordination of benefits (COB) occurs when a member has healthcare coverage under more than one plan.

10
10.1 DEFINITIONS

For purposes of section 11, the following definitions apply:

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

Plan includes

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

Plan does not include:

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

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

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

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

accordance with a contractual agreement is prohibited from charging a member is not an allowable expense.

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

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

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

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

10.2 How COB Works

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

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

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

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

10.3 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 (e.g. a retired

employee), then the order of benefits between the 2 plans is reversed.

b. **Dependent Child/Parents Married or Living Together.** If the member is a dependent child whose parents are married or living together whether or not they have ever been married, the plan of the parent whose birthday falls earlier in the calendar year is the primary plan. If both parents' birthdays are on the same day, the plan that has covered the parent the longest is the primary plan. (This is called the 'birthday rule.') If another plan does not include the birthday rule, but instead has a rule based on the gender of the parent, then that plan is the primary plan.
c. **Dependent Child/Parents Separated or Divorced or Not Living Together.** If the member is a dependent child of divorced or separated parents, or parents not living together whether or not they have been married, then the following rules apply:
    i. If a court decree states that one of the parents is responsible for the healthcare expenses of the child, and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to policy year commencing 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.** For a dependent child covered under the plans of both a parent and a spouse, the length of coverage provision below shall determine the order of benefits. If coverage under either or both parents' plans and the spouse's plans 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 that member as an employee, member of an organization, primary insured, or retiree or as a dependent of the same, is the primary plan and the COBRA or other continuation coverage is the secondary plan. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of the benefits, this rule is ignored.
h. **Longer/Shorter Length of Coverage.** The plan that covered a member longer is the primary plan and the plan that covered the member for the shorter period of time is the secondary plan.
i. **None of the Above.** If the preceding rules do not determine the order of benefits, the allowable expenses shall be shared equally between the plans. In addition, this Plan will not pay more than it would have paid had it been the primary plan.

10.4 COB AND PLAN LIMITS

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

11
12
13
14
15
15.5
15.6
15.7
15.8

10.5 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 9.1.4).

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 had it been the primary payer. This Plan will not pay more than the member's total out of pocket expense under the primary plan.

SECTION 11. MISCELLANEOUS PROVISIONS

11
11.1 MODIFICATION OF POLICY

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

11.2 RIGHT TO COLLECT AND 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.

11.3 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 information 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 888-447-8187.

11.4 TRANSFER OF BENEFITS

Only members are entitled to benefits under this policy. These benefits are not assignable or transferable to anyone else. Any attempted assignment or transfer will not be binding on Moda Health, except that Moda Health shall pay amounts due under this policy directly to a provider upon a member's written request.

11.5 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, within 12 months. 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.

11.6 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.

11.7 ENTIRE POLICY

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

11.8 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 received, since all those who provide care do so as independent contractors. Moda Health cannot be held liable for any claim or damages connected with injuries a member suffers while receiving medical services or supplies.

11.9 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.

11.10 GUARANTEED RENEWABILITY

Moda Health is required to renew coverage at the subscriber's option. Coverage may only be discontinued or non-renewed based on one or more of the following:

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

the coverage is provided) ceases but only if such coverage is terminated under this paragraph uniformly without regard to any health status-related factor of the members

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

a. **A healthcare insurance plan not offered.** In any case in which Moda Health decides to discontinue offering one healthcare insurance plan offered in the individual market, that plan may be discontinued only if:
    i. Moda Health provides notice to each subscriber covered under that plan of such discontinuation at least 90 days prior to the date of the discontinuation of that plan
    ii. Moda Health offers each subscriber covered under that plan the option to purchase any other individual healthcare insurance plan currently being offered for members in such market
    iii. in exercising the option to discontinue coverage of a plan and in offering the option of coverage under other plans as described in the preceding bullet, Moda Health acts uniformly without regard to any health status-related factor of a current or prospective member
b. **Discontinuance of all healthcare insurance plans.**
    i. In general. In any case in which Moda Health elects to discontinue offering all healthcare insurance plans in the individual market in a state, these plans may be discontinued only if:
        A. Moda Health provides notice to the applicable state authority and to each subscriber of such discontinuation at least 180 days prior to the date of the expiration of such plans
        B. all healthcare insurance issued or delivered for issuance in the state in such market is discontinued and coverage under such health insurance plans in such market is not renewed
    ii. Prohibition on market reentry. In the case of a discontinuation in the individual market as described in the preceding bullet, Moda Health may not provide for the issuance of any healthcare insurance plan in the market and the state involved during the 5-year period beginning on the date of the discontinuation of the last healthcare insurance plan not so renewed

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

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

11.11 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.

11.12 Governing Law

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

11.13 Where any Legal Action Must be Filed

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

11.14 Time Limit for Filing a Lawsuit

Any legal action arising out of, or related to, this policy and filed against Moda Health by a member or any third party must be filed in court at least 60 days, but no more than 3 years, after the time the claim was filed (see section 9.1.1). All internal levels of appeal under the Plan must be exhausted before filing a legal action in court.

11.15 Time Limit on Certain Defenses

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

11.16 Evaluation of New Technology

Moda Health develops medical necessity criteria for new technologies and new use of current technologies. The technology 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.

SECTION 12. MEMBERS' RIGHTS AND RESPONSIBILITIES

Members have the right to:

a. Be treated with respect and recognition of their dignity and need for privacy.
b. Have access to urgent and emergency services, 24 hours a day, 7 days a week.
c. Know what their rights and responsibilities are. Members will be given information about the Plan and how to use it, and about the providers who will care for them. This information will be provided in a way that members can understand.
d. Participate in decision making regarding their healthcare. This includes a discussion of appropriate or medically necessary treatment options for their conditions, whether or not the cost or benefit is covered by Moda Health, and the right to refuse care and to be advised of the medical result of their refusal.
e. Receive services as described in this policy.
f. Have their medical and personal information remain private. Personal information will be handled in compliance with state and federal law, and will be given to third parties only as necessary to administer the policy, as required by law, or as permitted by the member.
g. File a complaint or appeal about any aspect of the Plan, and to receive a timely response. Members are welcome to make suggestions to Moda Health.
h. Obtain free language assistance services, including verbal interpretation services, when communicating with Moda Health.
i. Have a statement of wishes for treatment, known as an Advanced Directive, on file with their professional providers. Members also have the right to file a power of attorney, which allows the member to give someone else the right to make healthcare choices when the member is unable to make these decisions.
j. Make suggestions regarding Moda Health's policy on members' rights and responsibilities.

Members have the responsibility to:

a. Read this policy to make sure they understand the policy. Members are advised to call Customer Service with questions.
b. Treat all providers and their staff with courtesy and respect.
c. Provide all the information needed for their provider to provide good healthcare.
d. Participate in making decisions about their medical care and forming a treatment plan.
e. Follow instructions for care they have agreed to with their provider.
f. Use urgent and emergency services appropriately.
g. Present their medical identification card when seeking medical care.
h. Notify providers of any other insurance policies that may provide coverage.
i. Reimburse Moda Health from any third party payments they may receive.
j. Keep appointments and be on time. If this is not possible, members must call ahead to let the provider know they will be late or cannot keep the appointment.
k. Seek regular health checkups and preventive services.
l. Provide adequate information to Moda Health 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.

EXHIBIT A – PRIOR AUTHORIZATION GUIDELINES

AUTHORIZATION INFORMATION
Authorization requests may be phoned in toll-free to 800-258-2037, or faxed to 503-243-5105.

AUTHORIZATION REQUEST REQUIREMENTS
The following information should be included with a prior authorization request

- All pertinent patient information (subscriber, ID #, group #, relation to subscriber, and patient's birth date)
- The name of the facility where the procedure is to be performed
- The date of the procedure or date of admission
- Full name of surgeon or specialist
- CPT & ICD (numeric only) codes
- Length of stay (indicate if outpatient)
- Chart notes and any other supporting documentation

SERVICES THAT DO NOT REQUIRE AUTHORIZATION

- Aspiration
- Biopsies
- Bone mineral density studies, diagnostic
- Brachytherapy for breast cancer
- Cardiovascular stress test
- Colonoscopy (not virtual)
- Diabetic shoes (unless more than $500 and/or more than 1 pair per year)
- ECG, EKG
- Echocardiography
- EEG
- EMG CPT: 95870
- Hydration therapy
- Kidney dialysis
- Routine lab tests
- Occupational therapy
- Physical therapy
- Speech therapy
- Trigger point injections
- Ultrasound
- X-rays

SERVICES THAT REQUIRE AUTHORIZATION

The following is a complete list of services and supplies that require authorization to determine medical necessity or plan benefit limitations. New and emerging developments in medical practice and improved standards of care and new FDA approved medications are subject to review and may have coverage requirements or limits. A list of any such services, supplies or medications will be available on myModa or by contacting Customer Service.

APPLIED BEHAVIOR ANALYSIS

CHEMICAL DEPENDENCY RESIDENTIAL AND PARTIAL HOSPITALIZATION SERVICES

COSMETIC PROCEDURES
Potentially cosmetic procedures may be an exclusion unless medical necessity has been established.

- Abdominoplasty
- Blepharoplasty and/or brow lift
- Botox injections
- Breast surgery - augmentation or reduction
- Dermabrasion
- Intralesional injections (i.e., Kenalog)
- Laser treatment (except for retinopathy)
- Lipectomy
- Otoplasty
- Panniculectomy
- Port wine stain treatment
- Rhinoplasty
- Scar revisions (includes Kenalog injections)
- Silicone breast implant removal
- Varicose vein surgery/sclerotherapy

DIAGNOSTIC PROCEDURES

- Genetic testing
- RAST allergy testing
- Positron emission tomography (PET) scans
- Single photon emission computed tomography (SPECT) scans
- CT scans,(including computed tomography angiogram (CTA)
- MRI (including MRA, MRS, MRM)
- Nuclear cardiology imaging studies
- fMRI
- Upper endoscopies
- Sleep studies
- Virtual colonoscopy

DURABLE MEDICAL EQUIPMENT/ APPLIANCES/SUPPLIES

- Airway clearance devices (chest percussors, vests, etc.)
- Augmentative communication device and system
- Bone growth stimulator
- Braces/orthotics over $3,000 (except custom-made foot orthotics)
- Continuous glucose monitor
- Custom compression stockings over $500
- Custom/special seating system
- Custom wheelchair (also repairs over $500)
- Dynasplint/JAS (or other mechanical stretching device)
- Enteral feedings/nutritional formulas
- External wearable cardiac defibrillator
- Gradient pressure aid
- Hospital bed
- Insulin pump
- Intrapulmonary percussive ventilation
- INR monitor, for home use
- Light box
- Wound vac (including wound warming cover)
- Low air loss products
- Muscle stimulator
- Nebulizer, portable over $300
- Oxygen (initial certification only)
- Patient lift
- Phototherapy lights (for dermatologic diagnosis)
- Power wheelchair/scooter (also repairs over $500)
- Prosthetics (except breast prosthetics)
- Sonic Accelerated Fracture Healing System
- Spinal cord stimulator
- Trapeze

EAR/NOSE/THROAT PROCEDURES

- Cochlear implantation/removal
- Otoplasty
- Septorhinoplasty
- Uvulopalatopharyngoplasty

- Rhinoplasty
- (UPPP)/Uvulectomy

EXPERIMENTAL OR INVESTIGATIONAL

- Active cooling devices (i.e., Game Ready)
- Anodyne Therapy System
- Automated, noninvasive nerve conduction study (e.g. NC-Stat)
- Bioelectrical impedance analysis
- Breast tomosynthesis (3D mammogram)
- Bronchial thermoplasty (Alair)
- Carotid Sinus Baroreflex Stimulation System (Rheos)
- Computer assisted navigation for musculoskeletal procedures
- Cryoablation of breast fibroadenomas
- Dynamic spine stabilization (Dynesys)
- ExMI (extracorporeal magnetic innervation)
- Intradiscal electrothermal therapy (IDET)
- High density lipid profile
- Home interferential muscle stimulator
- Microcurrent stimulators (MENS) (e.g. Alpha Stim unit)
- Micronutrient testing
- Mobile outpatient cardiac telemetry (MOCT)
- Myocardial sympathetic innervation imaging
- Nucleoplasty
- Optical coherence tomography
- Ossatron/orthotripsy/ESWT (extracorporeal shock wave therapy)
- Platelet rich plasma injections
- Prolotherapy
- Percutaneous lumbar discectomy and laser-assisted disc decompression
- Quantitative sensory testing
- Saliva hormone testing
- Subcutaneous implantable defibrillator
- Sublingual immunotherapy (SLIT)
- Somnoplasty™/Coblation
- Tissue grafts/mesh (biologic engineered from human or xenograft source)
- Thermal imaging/thermography
- Transcranial magnetic stimulation
- Vertebral axial decompression
- Wireless implantable pulmonary artery pressure sensor

HOME SERVICES

- Home health services
- Home infusion services
- Hospice care
- Palliative care

IMMUNOTHERAPY/ALLERGY AND INJECTIONS

Prior authorization is required for more than 56 units of CPT 95165 (56 units = 2 treatment sets at 28 doses per treatment set)

IMMUNIZATIONS

- Rabies Vaccine
- Zostavax for under age 60

INFUSION SERVICES (OUTPATIENT)

- Abraxane
- Adcetris
- Aloxi
- Alimta
- Amevive infusion
- Aredia
- Arzerra
- Avastin
- Benlysta
- Berinert
- Cinryze
- Cyramza
- Erbitux
- Entyvio
- Fabrazyme
- Fusilev
- GLASSIA
- Halaven
- Herceptin
- Intravenous immune globulin (IVIG)
- Iron, intravenous
- Jevtana
- Kadcyla
- Keytruda
- Krystexxa
- Kyprolis
- Lumizyme
- Marqibuo
- Opdivo
- Orencia, intravenous
- Perjeta
- Prolia
- Provenge
- Reclast
- Remicade
- Rituximab
- Simponi Aria
- Soliris
- Treanda
- Tysabri
- Vectibix
- Velcade
- Yervoy
- Zaltrap
- Zometa

INJECTABLE MEDICATIONS

- Acthar HP
- Botox
- Epogen
- Eylea
- Granix
- Kalbitor
- Lucentis
- Macugen
- Makena
- Neulasta
- Neupogen
- Rebetron
- Remodulin
- Synagis
- Xolair

INPATIENT STAY - ALL ADMISSION
Including substitution of care for hospitalization or other institutional expenses

INPATIENT REHABILITATION

MENTAL HEALTH RESIDENTIAL, PARTIAL HOSPITALIZATION AND INTENSIVE OUTPATIENT SERVICES

ORAL/MAXILLOFACIAL PROCEDURES

- Orthognathic services
- Treatment of dental accidents

PAIN MANAGEMENT

- Epidural pain pump insertion
- Multidisciplinary pain team evaluation
- Spine injections for chronic back pain
- Spinal cord stimulator (trial and permanent placement
- Synvisc, Supartz, Hyalgan, Orthovisc, Euflexxa injections (all viscosupplementation)

PHARMACEUTICAL

Certain prescription medications and/or quantities of prescription medications may require prior authorization. New FDA approved medications are subject to review and may be subject to additional coverage requirements or limits established by the Plan.

Prior authorization is required for:

- Retail prescriptions with a net cost over $1,500 for a 30-day supply
- Mail-order prescriptions with a net cost over $4,500
- Compounded medications with a net cost over $150 for a 30-day supply
- Medications in the following categories:
    - Allergy
    - Alzheimer disease
    - Anaphylactic agents
    - Angina (chest pain)
    - Anticoagulants
    - Antidepressants
    - Antiemesis/Antivertigo
    - Asthma
    - Behavioral health (ADHD, schizophrenia, bipolar disorder, insomnia, narcolepsy)
    - Contraceptives
    - Cystic fibrosis agents
    - Dermatology (antifungals, antivirals, antibacterials, anti-inflammatory)
    - Diabetes
    - Dyslipidemia
    - Electrolyte regulation
    - Endocrine disorders
    - Eye (anti-inflammatory, glaucoma)
    - Gout
    - Hormonal deficiency
    - Hypertension
    - Immunization
    - Immunosuppressives
    - Infectious disease (bacterial, viral)
    - Inflammatory disease
    - Lower gastrointestinal disorders
    - Neurologic disease
    - Pain management – analgesics
    - Parkinson's disease
    - Platelet-aggregation inhibitors
    - Pulmonary fibrosis agents
    - Seizure disorder
    - Smoking cessation
    - Upper gastrointestinal disorders (digestive, ulcer disease)
    - Urinary tract disorders

A complete list of medications that require prior authorization is available on myModa or by contacting Customer Service.

REHABILITATIVE AND RECUPERATIVE SERVICES

- Cardiac rehabilitation
- Pulmonary rehabilitation
- Multidisciplinary pain team evaluation

REPRODUCTIVE SERVICES

- DNA testing (including MaterniT21, Verifi, Harmony for high-risk pregnancy and age over 35)
- Genetic testing – assays with screening for multiple inheritable diseases must meet medical necessity criteria for each individual test (i.e., Counsyl)

SKILLED NURSING FACILITY

SURGERY – ALL INPATIENT ELECTIVE SURGERIES AND PROCEDURES

SURGERY/TREATMENT – OUTPATIENT

- Cartilage transplants of the knee
- Capsule endoscopy
- Circumcision after 3 months of age
- Eye surgery for cataracts with implant of intraocular telescopic lens
- Hyperbaric oxygen therapy
- Intraoperative neurophysiological monitoring for selected procedures
- Neck/back/spine surgeries
- Prophylactic surgery (e.g. mastectomy)
- Thoracic sympathectomy (for hyperhidrosis)
- Kyphoplasty/Vertebroplasty
- Stereotactic radiosurgery (i.e. Gamma knife
- Outpatient arthroscopies
- Hip, knee, shoulder surgeries

TRANSPLANTS

- All transplants except cornea
- Donor services

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

P.O. Box 40384
Portland, OR 97240

modahealth.com

4978645 (8/13)