



2026

Moda Health Plan, Inc.

Idaho Group Medical Plan

Moda Select Gold HDHP 3400 Plan

Insert Group Name

Insert Group Number

Insert Group's Effective Date

Health plans provided by Moda Health Plan, Inc.

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SECTION 1. WELCOME TO MODA HEALTH

We are pleased your Group has chosen Moda Health as its managed care plan. This handbook will give you important information about this Plan's benefits, limitations and procedures.

If you have questions, call one of the numbers listed in section 2.1 or use the tools and resources on your Member Dashboard at www.modahealth.com/idaho. You can use it 24 hours a day, 7 days a week to get your plan information whenever it is convenient.

This handbook may be changed or replaced at any time, by the Group or Moda Health, without your agreement. You can find the most current handbook on your Member Dashboard. All plan provisions are governed by the Group's policy with Moda Health. This handbook may not contain every plan provision.

We may monitor telephone conversations and email communications you have with us. We will only do this when Moda Health determines there is a legitimate business purpose to do so.

IMPORTANT NOTES:

ESSENTIAL HEALTH BENEFITS

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

This Plan does not include coverage for pediatric dental care, which is considered an essential health benefit under the Affordable Care Act. Pediatric dental care is available in the market and can be purchased as a stand-alone product. Please contact the Group for information, or Your Health Idaho if you wish to purchase a stand-alone dental care product.

SECTION 2. MEMBER RESOURCES

2.1 CONTACT INFORMATION

Moda Health Website (log in to the Member Dashboard)

www.modahealth.com/idaho

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

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

Medical Customer Service Department

1-844-248-7877

En español 888-786-7461

Behavioral Health Customer Service Department

888-217-2373

Disease Management and Health Coaching

877-277-7281

Hearing Services preferred vendor Customer Service

TruHearing

866-202-2178

Virtual Care preferred vendor

CirrusMD

Modahealth.com/cirrusmd

Pharmacy Customer Service Department

844-931-1780

Vision Care Services Customer Service Department

800-877-7195

Appeals Department

601 SW 2nd Ave., Portland, OR 97204

Fax 503-412-4003

IdahoAppealReview@modahealth.com

Telecommunications Relay Service for the hearing impaired

711

Moda Health

P.O. Box 40384

Portland, Oregon 97240

2.2 MEMBER ID CARD

After you enroll, we will send you ID (identification) cards that show your group and ID numbers, and your provider network. Show your card each time you receive services, so your provider will know you are a Moda Health member. If you lose your ID card, you can get a new one through your Member Dashboard or by calling Customer Service.

2.3 NETWORKS

Network Information (Section 5) explains how networks work. These are the networks for your Plan:

Medical network

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

Pharmacy network

Navitus

Vision network

VSP

2.4 CARE COORDINATION

2.4.1 Care Coordination

When you have a complex and/or catastrophic medical situation, our Care Coordinators and Case Managers will work directly with you and your professional providers to coordinate your healthcare needs. Care Coordinators and Case Managers are nurses or behavioral health clinicians. They will coordinate access to a wide range of services spanning all levels of care. Coordinating your care helps you get the right services at the right time.

2.4.2 Disease Management & Health Coaching

If you are living with a chronic disease or medical condition, we want to help you improve your health status, quality of life and productivity. Working with a Health Coach can help you follow the medical care plan your professional provider recommends. Health Coaches provide education and support to help you identify your healthcare goals, self-manage your disease and prevent the development or progression of complications. Contact Disease Management and Health Coaching for more information.

2.4.3 Behavioral Health

Moda Behavioral Health provides specialty services for managing mental health and substance use disorder benefits. We can help you access effective care in the right place and contain costs. Behavioral Health Customer Service can help you find in-network providers and understand your mental health and substance use disorder benefits.

2.5 OTHER RESOURCES

You can find other general information about this Plan in Section 13.

See Section 14 for information about additional services, programs and tools to support your physical, mental and emotional health. These resources are not part of this Plan, and they are not insurance.

SECTION 3. SCHEDULE OF BENEFITS

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

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

You will find details of the actual benefits in the sections after this summary. You will need to know the conditions, limitations and exclusions that are explained there. Prior authorization may be required for some services (see Section 6). Important terms are explained in Section 12.

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

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

	In-Network Benefits	Out-of-Network Benefits
Annual medical deductible per member	\$3,400	\$9,000
Maximum annual medical deductible per family	\$6,800	\$18,000
Annual out-of-pocket maximum per member	\$3,400	\$9,000
Maximum annual out-of-pocket maximum per family	\$6,800	\$18,000

Services	Cost Sharing		Section in Handbook & Details
	In-network	Out-of-network	
Urgent & Emergency Care			
Ambulance Transportation	0% In-network deductibles and out-of-pocket maximums apply		Section 7.2.1
Emergency Room Facility (includes ancillary services)	0% In-network deductibles and out-of-pocket maximums apply		Section 7.2.2 No copay if admitted
Urgent Care Office Visit	0% after deductible	0% after deductible	Section 7.2.3
Preventive Services			
Services as required under the Affordable Care Act, including the following:	0%	0% after deductible	Section 7.3
Colonoscopy	0%	0% after deductible	Section 7.3.1 One per 10 years, age 45+
Contraception	0%	0% after deductible	Section 7.3.2
Immunizations	0%	0% after deductible	Section 7.3.3

Services	Cost Sharing		Section in Handbook & Details
	In-network	Out-of-network	
Mammogram	0%	0% after deductible	Section 7.3.8 One per year, age 40+
Pediatric Screenings	0%	0% after deductible	Section 7.3.4 Age/frequency limits apply
Preventive Health Exams	0%	0% after deductible	Section 7.3.5 6 visits in first year of life 7 exams from age 1 - 4 One per year, age 5+
Tobacco Cessation Treatment			
Consultation & Supplies	0%	0% after deductible	Section 7.3.7
Women's Exam & Pap Test	0%	0% after deductible	Section 7.3.8 One per year. Supplemental breast cancer screening as described in Section 7.3.8
Other Preventive Services including:			
Screening X-ray & Lab	0% after deductible	0% after deductible	Section 7.4.9
Prostate Rectal Exam			Section 7.3.6 Once every year
Selected PCP	0% after deductible	0% after deductible	
Other providers	0% after deductible	0% after deductible	
Prostate Specific Antigen (PSA) Test	0% after deductible	0% after deductible	
General Treatment Services			
Acupuncture	0% after deductible	0% after deductible	Section 7.4.1 20 visits per year
Anticancer Medication	0% after deductible	0% after deductible	Section 7.4.2
Applied Behavior Analysis	0% after deductible	0% after deductible	Section 7.4.3
Behavioral Health Services			Section 7.4.4
Detoxification (Detox)	0% after deductible	0% after deductible	
Intensive Outpatient	\$20 per visit	0% after deductible	
Other Outpatient Services	\$20 per visit	0% after deductible	
Inpatient	0% after deductible	0% after deductible	
Partial Hospitalization	0% after deductible	0% after deductible	
Residential Treatment Program	0% after deductible	0% after deductible	

Services	Cost Sharing		Section in Handbook & Details
	In-network	Out-of-network	
Biofeedback	\$40 per visit	0% after deductible	Section 7.4.5 10 visit lifetime maximum
Dental Injury	0% after deductible	0% after deductible	Section 7.4.7
Diabetes Services	0% after deductible	0% after deductible	Section 7.4.8 Supplies covered under Pharmacy benefits
Diagnostic Procedures, including x-ray and lab			Section 7.4.10
Outpatient	0% after deductible	0% after deductible	
Inpatient	0% after deductible	0% after deductible	
Advanced Imaging	0% after deductible	0% after deductible	
Durable Medical Equipment (DME) Supplies & Appliances	0% after deductible	0% after deductible	Section 7.4.10
Hearing Aids & Related Services			Section 7.4.13 Frequency limits apply
Hearing Evaluation	\$45 per visit	0% after deductible	
Other services	0% after deductible	0% after deductible	
Home Healthcare	0% after deductible	0% after deductible	Section 7.4.14
Hospice Care			Section 7.4.15
Home Care	0% after deductible	0% after deductible	
Inpatient Care	0% after deductible	0% after deductible	
Respite Care	0% after deductible	0% after deductible	
Hospital Inpatient Care	0% after deductible	0% after deductible	Section 7.4.16
Hospital Physician Visits	0% after deductible	0% after deductible	Section 7.4.17
Infusion Therapy (Home or Outpatient)	0% after deductible	0% after deductible	Section 7.4.19 Some medications may be limited to certain providers or settings. Certain medications covered under specialty pharmacy benefit.
Kidney Dialysis	0% after deductible	0% after deductible	Section 7.4.20
Nutritional Therapy			Section 7.4.24
Preventive, as required under the Affordable Care Act	0%	0% after deductible	

Services	Cost Sharing		Section in Handbook & Details
	In-network	Out-of-network	
Treatment (medical and behavioral health)	0% after deductible	0% after deductible	Nutritional therapy for eating disorders must be authorized after first 5 visits
Office and Home Visits			Section 7.4.25 See also Virtual Care Visits under Other Services
PCP Visits	0% after deductible	0% after deductible	
Specialist Visits	0% after deductible	0% after deductible	
Rehabilitation & Habilitation(Physical, occupational and speech therapy)			Section 7.4.28 Up to 20 outpatient sessions per year. Limits apply separately to rehabilitation and habilitation services. Limits do not apply to behavioral health
Outpatient	0% after deductible	0% after deductible	
Inpatient	0% after deductible	0% after deductible	
Skilled Nursing Facility Care	0% after deductible	0% after deductible	Section 7.4.29 30 days per year
Spinal Manipulation	0% after deductible	0% after deductible	Section 7.4.30 20 visits per year
Surgery & Invasive Diagnostic Procedures			Section 7.4.31
Outpatient	0% after deductible	0% after deductible	
Inpatient	0% after deductible	0% after deductible	
Therapeutic Injections	0% after deductible	0% after deductible	Section 7.4.32
Therapeutic Radiology	0% after deductible	0% after deductible	Section 7.4.33
Transplants			Section 7.4.34 Up to 14 days per transplant for travel and housing
Center of Excellence facilities	0% after deductible	0% after deductible	
Other facilities	0% after deductible	0% after deductible	
Virtual Care Visits			Section 7.4.35 Log on via modahealth.com/cirrusmd
Through CirrusMD	0% after deductible	N/A	
Other providers	0% after deductible	0% after deductible	
Maternity Services			
Breastfeeding			Section 7.5.1
Support and Counseling	0%	0% after deductible	
Supplies	0%	0%	

Services	Cost Sharing		Section in Handbook & Details
	In-network	Out-of-network	
Maternity	0% after deductible	0% after deductible	Section 7.5
Pharmacy			
Prescription Medication	If you use an out-of-network pharmacy, you must pay any amounts charged above the MPA		Section 7.6
Retail Pharmacy			Up to 90-day supply per prescription One copay for a 30-day supply
Value Tier	0%	0%	
Select Tier	0% after deductible	0% after deductible	
Preferred Tier	0% after deductible	0% after deductible	
Nonpreferred Tier	0% after deductible	0% after deductible	
Mail Order Pharmacy			Up to 90-day supply per prescription Must use Moda-designated mail order pharmacy or pharmacies that agree to follow our terms for mail order pharmacies
Value Tier	0%	0%	
Select Tier	0% after deductible	0% after deductible	
Preferred Tier	0% after deductible	0% after deductible	
Nonpreferred Tier	0% after deductible	0% after deductible	
Specialty Pharmacy			Prior authorization required for non-Moda-designated specialty pharmacies. Up to 30-day supply per prescription for most medications
Preferred Specialty	40% after deductible	40% after deductible	
Nonpreferred Specialty	50% after deductible	50% after deductible	
Anticancer Medication	0% after deductible	0% after deductible	Section 7.4.2 Prior authorization required for non-Moda-designated specialty pharmacies.
Vision			
Pediatric Vision Care			Section 7.4.36 Under age 19 No deductible
Exam	0%	50%	One per year
Lenses & frames or contacts	0%	50%	One pair per year Frames from the Otis & Piper Eyewear collection only
Optional Lenses and Treatments	0%	50%	

Services	Cost Sharing		Section in Handbook & Details
	In-network	Out-of-network	
Low vision evaluation	0%	50%	One every year
Low vision services	0%	50%	4 visits every 5 years for follow up care
Low vision aids	0%	50%	One low vision aid per year and one pair of high power spectacles per year

SECTION 4. PAYMENT & COST SHARING

4.1 DEDUCTIBLES

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

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

If the Group has changed coverage to a policy with Moda Health, we will credit any deductible you met under your old plan during the year to your new Moda Health Plan.

Your deductible is added up on a calendar year basis. If this Plan renews on a date other than January 1st, you may have to meet some additional deductible after renewal through December 31st.

4.2 MAXIMUM OUT OF POCKET

This Plan helps protect you from very high medical costs. The out-of-pocket maximum is an upper limit on how much you have to pay for covered charges each year. Once you have paid the maximum amount, this Plan will pay 100% of covered services for the rest of the year. If more than one member of your family is covered, the per member maximum applies only until the total family out-of-pocket maximum is reached, even if no single family member has reached the per member maximum. In-network and out-of-network out-of-pocket maximums add up separately and are not combined.

Out-of-pocket costs are added up on a calendar year basis. If this Plan renews on a date other than January 1st, you may have to pay more out-of-pocket costs after renewal through December 31st.

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

You will always have to pay disallowed charges, and out-of-pocket expenses for transplants not performed at a center of excellence even after your out-of-pocket maximum is met. Disallowed charges may include amounts over the MPA and expenses incurred due to brand substitution.

If the Group has changed coverage to a policy with Moda Health, we will credit any out-of-pocket maximum amount you met under your old plan during the year to your new Moda Health Plan.

4.3 PAYMENT

Moda Health pays covered expenses based on the maximum plan allowance (MPA). The MPA is defined in Section 12. You may have to pay some of the charges (cost sharing). What you have to pay depends on the Plan provisions.

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

4.4 EXTRA-CONTRACTUAL SERVICES

Moda Health works with you and your professional providers to consider effective alternatives to hospitalization and other care to make more efficient use of this Plan's benefits. If we believe a service or supply is medically necessary, cost effective and beneficial for quality of care, we may cover the service or supply even though this Plan does not allow it. This is called an extra-contractual (outside the Plan contract) service.

After case evaluation and analysis by Moda Health, extra-contractual services will be covered when Moda Health, and you and your professional provider agree. Any of us can end these services by giving notice in writing.

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

SECTION 5. NETWORK INFORMATION

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

When you are at an in-network facility, your care may be provided by physicians, anesthesiologists, radiologists or other professionals who are not in-network. When you receive services from these out-of-network providers, you may have to pay any amounts charged above the MPA when permitted by law (see section 5.1.3). This is called balance billing. Remember to ask providers to send any lab work or x-rays to an in-network facility.

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

5.1 GENERAL NETWORK INFORMATION

5.1.1 Network and Service Area

Your network provides services in your service area. If the subscriber lives outside the primary service area, you may have other networks you can use. Subscribers who move outside of their network service area must contact Customer Service to find out if another network is available, so you can continue to access in-network providers.

Ask your providers (both professional providers and facilities) if they participate with the specific network listed below. Contact Customer Service if you need help finding an in-network provider:
1-844-248-7877
En español 888-786-7461

Networks

- Pharmacy network is Navitus
- Vision network is VSP
- Medical networks:

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

Idaho – Counties outside the network service area defined above	Aetna® PPO, Moda Select, Connexus
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Where the subscriber lives	Network name	Network service area
Alaska	Moda Select, Connexus, Aetna® PPO	
Oregon, Southwest Washington	Moda Select, Connexus, Aetna® PPO	Oregon, Clark and Cowlitz counties
Washington	Aetna® PPO, Moda Select, Connexus	Washington outside of Clark and Cowlitz counties
All other areas	Aetna® PPO, Moda Select, Connexus	All states except Alaska service area, Idaho service area, Oregon service area and southwest Washington service area

5.1.2 Coverage Outside the Service Area for Children

Enrolled children living in the United States but outside the service area may be assigned to the out-of-area network.. Covered services by providers not participating in the out-of-area network are at a lower benefit level.

When your enrolled child moves outside the service area, you must contact Customer Service and your employer to update their address with us. Access to the out-of-area network starts on the first day of the month after we have updated the address in our system.

If your child is living outside the service area for the purpose of receiving treatment, services will be out-of-network.

Out-of-Area Network

For children living i outside the Idaho service area – Aetna® PPO, Moda Select, Connexus Find an out-of-area network provider by using Find Care on your Member Dashboard. You may contact Customer Service if you need help.

When out-of-area children are traveling in the network service areas defined above, they must use those networks, even though they are assigned to the out-of-area network. Tell us when your child moves back into the primary service area.

5.1.3 Out-of-Network Care

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

When you are getting care at an in-network facility, ask to have related services (such as diagnostic testing, equipment and devices, telemedicine, anesthesia, surgical assistants)

performed by in-network providers. When you are at an in-network facility and are not able to choose the provider, you will have the in-network cost sharing for services by out-of-network providers. The provider cannot balance bill you unless permitted by law.

5.1.4 Care After Normal Office Hours

In-network professional providers have an on-call system so you can reach them 24 hours a day. If you need to talk to your professional provider after normal office hours, call their regular office number.

5.2 PCPs & OTHER PROVIDERS

Your Plan covers healthcare coordinated by a primary care provider (PCP). It is designed to help you make appropriate healthcare decisions. A PCP is a professional provider who specializes in family practice, general practice, internal medicine, women's healthcare or pediatrics.

The PCP you choose will coordinate your medical care, including arranging prior authorizations when needed. Most PCPs can be reached 24 hours a day. If you need to contact your PCP after normal office hours, call the regular office number.

If you do not select a PCP and get services from that PCP or another PCP within that clinic, your claims will be paid at a lower benefit level.

5.2.1 How to Select a PCP

You are encouraged to choose an in-network PCP and tell us who it is when you enroll. Each member of your family may choose a different PCP. Find a PCP online by using Find Care on your Member Dashboard. Contact the PCP to make sure they are accepting new patients. Once you have chosen a PCP, you can use your Member Dashboard to select the PCP for each covered family member or contact Customer Service for help. To change the PCP selection at any time, choose a new PCP and update the selection in your Member Dashboard or by calling Customer Service.

5.2.2 PCP Care

Your selected PCP is the first professional provider you should go to for advice about medical care, unless it is an emergency. Your PCP will provide and/or coordinate all of your healthcare needs. You will get the highest benefit level when you get services from your PCP. If your selected PCP is unavailable, the clinic will arrange for another in-network professional provider to be responsible for your care. When you get care from another PCP in the same clinic, those services will be paid at the same benefit level as services from your selected PCP. If your PCP refers you to a specialist, the specialist will take care of any prior authorizations you need.

If you have never received services from your selected PCP, the first step to establish a relationship is to contact the PCP's office. They may need information such as a copy of your member ID card and contact information for your previous primary care providers so your medical records can be transferred.

5.2.3 Other In-Network Primary Provider Care

You may use any in-network provider, but all care should be coordinated by your PCP. There are prior authorization requirements for certain services (see section 6.1). You may see an in-network women's healthcare provider for preventive women's health exams and other gynecological

care, and for pregnancy care. A women’s healthcare provider is an in-network obstetrician or gynecologist, physician assistant or advanced registered nurse practitioner specializing in women’s health, or certified nurse midwife, practicing within their lawful scope of practice. To select a women’s healthcare provider as your PCP, they must meet certain standards and must have requested and received designation from us as a PCP.

5.2.4 Out-of-Network Provider Care

We work with your PCP to encourage them to refer you to in-network providers whenever possible. These providers have agreed to cooperate in our quality assurance and utilization review programs. Make sure a provider you have been referred to is in-network. Do this by using Find Care on your Member Dashboard. When you choose healthcare providers that are not in-network, your benefits are at the lower, out-of-network level shown in Section 3. You may have to pay all of the charges when you get the treatment, and then file a claim to get your out-of-network benefits. If the provider’s charges are more than the maximum plan allowance, you may be balance billed and have to pay those excess charges.

5.3 USING FIND CARE

Find Care is our online directory of in-network providers. To search for in-network providers, log in to your Member Dashboard at modahealth.com and click on Find Care.

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

5.3.1 Primary Care Providers

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

- a. Choose the “PCP ” option under the Type drop down menu
- b. Enter ZIP code and Search

The search will bring up a list of PCPs.

5.3.2 DME Providers

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

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

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

SECTION 6. PRIOR AUTHORIZATION

We use prior authorization to make sure your treatments are safe, that services and medications are used correctly, and that cost effective treatment options are used. When a service requires prior authorization, we evaluate it using evidence based criteria that align with medical literature, best practice clinical guidelines and guidance from the FDA. We will authorize medically necessary services, supplies or medications based on your medical condition. You may be required to use a preferred treatment center or provider for the treatment to be covered. Treatments are covered only when there is medical evidence of need.

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

6.1 PRIOR AUTHORIZATION REQUIREMENTS

When you use an out-of-network provider, you are responsible for making sure that your provider contacts us for prior authorization. If your services are not authorized in advance, we will apply a penalty of 0% up to a maximum deduction of \$2,500 for each occurrence before regular plan benefits begin. The prior authorization penalty does not count toward your deductible or out-of-pocket maximum.

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

6.1.1 Services Requiring Prior Authorization

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

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

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

6.1.2 Prior Authorization Limitations

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

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

Any limits or requirements that apply to authorized services will be described in the authorization letter that is sent to you and your provider. If you are working with a Care Coordinator or Case Manager (see section 2.4), they can help you understand how to access your authorized treatment.

6.1.3 Second Opinion

We may ask you to see another provider for an independent consultation to confirm that non-emergency treatment is medically necessary. When we do this, you will only have to pay your deductible for the second opinion.

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

SECTION 7. BENEFIT DESCRIPTION

This Plan covers services and supplies described in this handbook when they are medically necessary to diagnose and/or treat a medical condition, or are preventive services. We explain the benefits and the conditions, limitations and exclusions in the following sections. An explanation of important terms is in Section 12.

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

Many services must be prior authorized (see section 6.1). If your services are not authorized in advance or you do not use the authorized provider, we may not pay any benefits. You may have to pay the full charge or a prior authorization penalty.

7.1 WHEN BENEFITS ARE AVAILABLE

This Plan only pays claims for covered services you get when your coverage is in effect. Coverage is in effect when:

- a. You meet the eligibility provisions of this Plan
- b. You have applied for coverage and we have enrolled you on this Plan
- c. The Group has paid your premiums on time for the current month

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

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

7.2 URGENT & EMERGENCY CARE

Emergency services and urgent care are covered. Emergency services are covered at the in-network benefit level. You are covered for treatment of emergency medical conditions (as defined in Section 12) worldwide. If you believe you have a medical emergency, call 911 or seek care from the nearest appropriate provider.

If you get emergency care outside the United States, you will have to pay for those services at that time and send a claim to us as described in section 9.1.

7.2.1 Ambulance Transportation

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

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

7.2.2 Emergency Room Care

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

All claims for emergency services (as defined in Section 12) will be paid at the in-network benefit level. Even when you use an in-network emergency room, some of the providers working in the emergency room and/or hospital may be out-of-network providers (see section 5.1.3 for more information). These out-of-network providers may not bill you, and you do not have financial responsibility, for an amount greater than the applicable cost sharing and deductible under this Plan. Likewise, at an out-of-network emergency room, you cannot be balance billed except when permitted by law.

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

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

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

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

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

7.2.3 Urgent Care

When you have a minor but urgent medical condition that is not a significant threat to your life or health, short-term medical care at an urgent care facility is covered. You must be actually examined by a professional provider.

An urgent care facility is an office or clinic distinct from a hospital emergency room. Its purpose is to diagnose and treat illness or injury for patients without an appointment who are seeking immediate medical attention.

Note: Most walk-in or same-day clinics and immediate care facilities do not bill as urgent care facilities. If you go to one of these facilities, the visit will be covered under the office visit benefit (section 7.4.26). Services will not be paid under your urgent care benefits unless the facility you go to bills as an urgent care facility.

7.3 PREVENTIVE SERVICES

Under the Affordable Care Act (ACA), certain services are covered at no cost to you when you get the care from an in-network provider (see Section 3 for benefit level when services are provided out-of-network). Coverage limitations are based on reasonable medical management techniques where permitted by the ACA. This means that you may have member cost sharing for some alternatives in the services listed below:

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

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

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

7.3.1 Colorectal Cancer Screening

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

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

With the exception of colonoscopy, screening tests involve 2 steps. If you have a positive result on a USPSTF-recommended screening covered under the preventive benefit, one follow-up colonoscopy to confirm the results of the original screening will also be covered under the preventive benefit.

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

These screening timelines apply to you if you are not at high risk for colorectal cancer. You may be screened earlier or more often if it is medically necessary.

If you are at high risk for colorectal cancer, screening exams and laboratory tests are covered as recommended by your professional provider. You are high risk if you have a family medical history of known genetic disorders that predispose you to a high lifetime risk of colorectal cancer (such as Lynch syndrome), having had colorectal cancer or an adenomatous polyp before, or having had inflammatory bowel disease. Screening exams and laboratory tests, including a follow-up colonoscopy to check progress of the original finding, are paid at the medical benefit level if you do not meet the criteria for the USPSTF A or B rated recommendation.

7.3.2 Contraception

All FDA approved contraceptive methods, including hormonal contraceptives (oral, injectable, patch, ring), devices such as IUDs and implantables (including insertion and removal), and diaphragms and cervical caps. The plan also covers sterilization, and counseling. You can find a complete and current list of FDA-approved contraceptive methods here: [Birth Control Chart English \(fda.gov\)](https://www.fda.gov/oc/contraception). When you use an in-network provider and the most cost effective option (e.g., generic instead of brand name), you will not have to pay for contraception except for a vasectomy that is subject to standard cost sharing. If your provider determines the cost-effective contraceptive is medically inadvisable for you, we will cover an alternative that they prescribe at no cost sharing. Over the counter contraceptives are covered under the Pharmacy benefit (section 7.6.2). Surgery to reverse a vasectomy or tubal ligation is not covered.

7.3.3 Immunizations

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

7.3.4 Pediatric Screenings

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

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

7.3.5 Preventive Health Exams

Covered according to the following schedule:

- a. Newborn: One hospital visit
- b. Infants: 6 well-baby visits during the first year of life
- c. Age 1 to 4: 7 exams
- d. Age 5 and above: One exam every year

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

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

7.3.6 Prostate Cancer Screening

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

7.3.7 Tobacco Cessation

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

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

7.3.8 Women's Healthcare

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

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

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

Supplemental Breast Cancer Screening

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

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

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

7.4 GENERAL TREATMENT SERVICES

All services must be medically necessary. Many outpatient services must be prior authorized. All nonemergency inpatient and residential care must be prior authorized.

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

7.4.1 Acupuncture

A limited number of visits are covered each year. Other services you may get at an acupuncture visit, such as office visits or diagnostic services, are not covered under this benefit. They are paid under this Plan's standard benefit for the type of service. Office visits by acupuncturists are specialist office visits.

7.4.2 Anticancer Medication

Prescribed anticancer medications, including oral, intravenous (IV) or injected medications, are covered. Most anticancer medications need to be prior authorized and have specific benefit limitations. You must get specialty anticancer medications from our designated specialty pharmacy or get prior authorization to use a non-designated pharmacy (see section 7.6.5). For some anticancer medications, you may have to enroll in programs to help make sure the medication is used correctly and/or lower the cost of the medication. You can find more information on your Member Dashboard or by contacting Customer Service.

7.4.3 Applied Behavior Analysis (ABA)

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

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

Examples of what we do not cover:

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

7.4.4 Behavioral Health

Behavioral health conditions are mental health and substance use disorders covered by the diagnostic categories listed in the most current edition of the International Classification of Disease or Diagnostic and Statistical Manual of Mental Disorders.

Intensive outpatient mental health treatment, ACT, STAR and TMS must be prior authorized. See section 7.4.10 for coverage of diagnostic services.

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

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

A partial hospital program is an appropriately licensed behavioral health facility providing no less than 4 hours of direct, structured treatment services per day. Programs provide 20 or more hours of direct treatment per week. Partial hospital programs do not provide overnight 24-hour per day care.

A residential program is a program or facility providing an organized full-day or part-day program of treatment. Residential programs provide overnight 24-hour per day care and include programs to treat behavioral health conditions. Residential program does not include any program that provides less than 4 hours per day of direct treatment services. A residential program or facility must be state-licensed for services to be covered.

Mental Health

The following services by a mental health provider are covered:

- a. Office or home visits, including psychotherapy
- b. Intensive outpatient program
- c. Case management, skills training, wrap-around services and crisis intervention
- d. Assertive Community Treatment (ACT) and Strength through Active Recovery (STAR) programs
- e. Transcranial magnetic stimulation (TMS) and electroconvulsive therapy
- f. Partial hospitalization, inpatient and residential mental health care

Substance Use Disorder Services

Substance use disorder is an addictive physical and/or psychological relationship with any drug or alcohol that interferes on a recurring basis with main life areas such as employment, and psychological, physical and social functioning. Substance use disorder does not mean an addiction to or dependency upon foods, tobacco or tobacco products. Services to assess and treat substance use disorder in an outpatient treatment program are covered, including:

- a. Outpatient treatment programs. These are state-licensed programs that provide an organized outpatient course of treatment, with services by appointment.
- b. Room and treatment services for substance use detoxification by a state-licensed treatment program.

7.4.5 Biofeedback

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

7.4.6 Clinical Trials

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

This Plan does not cover items or services:

- a. That are not covered by this Plan if you get them outside of the clinical trial. This includes the drug, device or service being tested, even if it is covered in a different use outside of the clinical trial
- b. Required only to provide or appropriately monitor the drug, device or service being tested in the clinical trial

- c. Provided only for data collection and analysis needs and that are not used for your direct medical care
- d. Usually provided by a clinical trial sponsor free of charge to anyone participating in the clinical trial

We must prior authorize your participation in a clinical trial.

Approved clinical trials are limited to those that are:

- a. Funded or supported by a center or cooperative group that is funded by the National Institutes of Health, the Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, the Centers for Medicare and Medicaid Services, the U.S. Department of Energy, the U.S. Department of Defense or the U.S. Department of Veterans Affairs
- b. Conducted as an investigational new drug application, an investigational device exemption or a biologics license application to the U.S. Food and Drug Administration
- c. Exempt by federal law from the requirement to submit an investigational new drug application to the U.S. Food and Drug Administration

7.4.7 Dental Injury

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

- a. The accidental injury must have been caused by a foreign object or was caused by acute trauma (for example, if your tooth breaks when you are biting or chewing food, that is not an accidental injury)
- b. Diagnosis is made within 6 months of the date you were injured
- c. Treatment is completed within 12 months of the date of injury
- d. Treatment is medically necessary and you get it from a physician or dentist while you are enrolled in this Plan
- e. Treatment is limited to that which will restore your teeth to a functional state

Implants and implant related services are not covered.

7.4.8 Diabetes Services

Insulin and diabetic supplies including insulin syringes, needles and lancets, test strips, glucometers and continuous glucose monitors are covered under the pharmacy benefit (section 7.6.2), when you buy them from a pharmacy with a valid prescription and using a preferred manufacturer (see the preferred drug list on your Member Dashboard). Insulin pumps may be covered under the DME benefit (section 7.4.11) if you do not get them from a pharmacy.

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

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

- f. Routine foot care (see section 7.4.27)

7.4.9 Diagnostic Procedures

Services must be for treatment of a medical or behavioral health condition. Diagnostic services include:

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

Your provider must get prior authorization for most advanced imaging services (see section 6.1). This includes radiology (such as MR procedures like MRA and MRI, CT, PET and nuclear medicine) and cardiac imaging. A full list of diagnostic procedures that must be prior authorized is on the Moda Health website, or you may ask Customer Service.

7.4.10 Durable Medical Equipment (DME), Supplies & Appliances

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

Some examples of DME, supplies and appliances are:

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

Diabetic supplies, other than insulin pumps and related supplies, are only covered when you get them from a pharmacy. You must have a prescription and use a preferred manufacturer (see section 7.6.2 for coverage under Pharmacy benefit).

This Plan covers the rental charge for DME. For most DME, the rental charge is covered up to the purchase price. You can work with your providers to order your prescribed DME.

We encourage you to use a preferred DME provider. You may save money when you do. You can find a preferred provider using Find Care on your Member Dashboard (see section 5.3.2). Change your recurring prescription or automated billing to a preferred DME provider by contacting your current provider and the preferred DME provider and asking for the change.

All supplies, appliances and DME must be medically necessary. Your provider may have to prior authorize some DME (see Section 6). Replacement or repair is only covered if the appliance,

prosthetic, equipment or DME was not abused, was not used beyond its specifications and not used in a way that voids its warranty. If we ask you to, you must authorize anyone supplying your DME to give us information about the equipment order and any other records we need to approve a claim payment.

Exclusions

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

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

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

7.4.11 Enterostomal Therapy

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

7.4.12 Gender Affirming Services

Expenses for gender affirming treatment are covered for members over age 18 when you meet the following conditions:

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

Covered services may include:

- a. Mental health
- b. Surgical procedures (see section 7.4.32):
 - i. Breast/chest surgery
 - ii. Gonadectomy (hysterectomy/oophorectomy or orchiectomy)
 - iii. Reconstruction of the genitalia
 - iv. Gender affirming facial surgery

7.4.13 Hearing Services

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

- a. Hearing evaluations
- b. One hearing aid per hearing impaired ear every 36 months

- c. Bone conduction sound processors, including examinations and fittings
- a. Ear molds and replacement ear molds
- b. Outpatient speech therapy up to 45 visits every year when billed for hearing loss
- c. Cochlear implants when medically necessary and prior authorized

For other enrolled members, this Plan covers these items once every 3 years:

- a. Hearing evaluation
- b. One hearing aid per hearing impaired ear
- c. Bone conduction sound processors, including examinations and fittings
- d. Ear molds and replacement ear molds

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

To get the highest benefit level for hearing services, call the Hearing Services preferred vendor to choose an in-network audiologist and schedule a hearing exam. The audiologist will help you choose hearing aids from the selection available to our members by the hearing services vendor through an in-network hearing instrument provider. You can also use other in-network and out-of-network providers, but you may pay more.

Cochlear implants are covered when medically necessary and prior authorized.

7.4.14 Home Healthcare

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

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

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

Home health aides are not covered. If you are in hospice, your home healthcare, home care services and supplies are covered under section 7.4.11 and section 7.4.16.

7.4.15 Hospice Care

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

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

plan must describe the services and supplies for medically necessary or palliative care the approved hospice will provide.

Hospice Home Care

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

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

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

Hospice Inpatient Care

Short term hospice inpatient services and supplies are covered.

Respite Care

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

Exclusions

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

- a. Hospice services provided to other than the terminally ill member, including out of network bereavement counseling for family members
- b. Services and supplies that are not included in your hospice treatment plan or not specifically listed as a hospice benefit

7.4.16 Hospital Care

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

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

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

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

7.4.17 Hospital Visits

This is when you are actually examined by a professional provider in a hospital. Covered expenses include consultations with written reports and second opinion consultations.

7.4.18 Inborn Errors of Metabolism

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

7.4.19 Infusion Therapy

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

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

You may have to use a preferred medication supplier, home infusion provider or provider office infusion for some medications. When we limit authorization to a certain supplier, provider or setting, medications you get from other suppliers or infusion therapy administered at a hospital outpatient facility or other in-network provider may not be covered. Some infusion medications from a preferred medication supplier are covered under the pharmacy specialty medication benefit (see Section 3 and section 7.6.5). See section 7.6.6 for self-administered infusion therapy.

Some services and supplies are not covered if your provider bills them separately. They are considered included in the cost of other billed charges.

7.4.20 Kidney Dialysis

Covered expenses include:

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

7.4.21 Maxillofacial Prosthetic Services

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

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

The problem must be because of:

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

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

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

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

Some medications will not be covered unless you use a preferred treatment center. The treatment program may include office visits, testing, a stay at the treatment center and the medication. Sometimes travel expenses may be included. Treatment must be prior authorized (see section 6.1).

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

See section 7.4.20 for more information about infusion therapy. Self-administered medications are not covered under this benefit (see section 7.6.6). See section 0 for pharmacy benefits.

7.4.23 Nonprescription Enteral Formula for Home Use

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

7.4.24 Nutritional Therapy

Dietary or nutritional therapy is covered for certain conditions (but not for obesity). Nutritional therapy for eating disorders must be authorized after the first 5 visits. Preventive nutritional therapy required under the Affordable Care Act is covered under the preventive care benefit. Also see diabetes services (section 7.4.9) and inborn errors of metabolism (section 7.4.19).

7.4.25 Office or Home Visits

A visit means you are actually examined by a professional provider. Covered expenses include consultations with written reports and second opinion surgery consultations. Office visits by naturopathic medical doctors are specialist office visits unless we have credentialed the naturopathic physician as a primary care provider.

7.4.26 Podiatry Services

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

7.4.27 Pre-admission Testing

Pre-admission testing is covered when ordered by your professional provider.

7.4.28 Rehabilitation & Habilitation

Covered rehabilitation and habilitation services are:

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

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

- a. Medically necessary
- b. Part of your professional provider's written treatment plan to improve and restore lost function following illness or injury
- c. Inpatient services are in a hospital or other inpatient facility that specializes in such care

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

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

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

7.4.29 Skilled Nursing Facility Care

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

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

Exclusions

These skilled nursing facility charges are not covered:

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

7.4.30 Spinal Manipulation

A limited number of visits are covered each year. Other services you may get at a spinal manipulation visit, such as office visits, lab and diagnostic x-rays, or physical therapy, are not covered under this benefit. They are paid under this Plan's standard benefit for the type of service. Office visits by chiropractors are specialist office visits.

7.4.31 Surgery

Surgery (operations and cutting procedures), including treating broken bones, dislocations and burns, is covered. Operating rooms and recovery rooms, surgical supplies and other services ordinarily provided by a hospital or surgical center are covered. The surgery cost sharing also applies to these services:

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

Certain surgical procedures are covered only when performed as outpatient surgery. Ask your professional provider if this applies to a surgery you are planning, or ask Customer Service. Outpatient surgery does not require an inpatient admission or a stay of 24 hours or more.

Cosmetic & Reconstructive

Cosmetic surgery is surgery that maintains or changes how you look. It does not improve how your body works. Reconstructive surgery repairs a birth defect or an abnormality caused by

injury, infection, tumor or disease. Reconstructive surgery is usually done to improve how your body works, but may also be used to approximate a normal appearance.

Cosmetic surgery is not covered. All reconstructive procedures must be medically necessary and prior authorized or benefits will not be paid. Reconstructive surgery that is partially cosmetic may be covered if it is medically necessary. This includes services to treat a covered mental health condition, such as gender dysphoria.

Surgery for breast enhancement, making breasts match, and replacing breast implants to change the shape or size of your breasts is not covered except to treat gender dysphoria (see section 7.4.13) or after a mastectomy.

Reconstructive surgery after a medically necessary mastectomy includes:

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

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

7.4.32 Therapeutic Injections

Administrative services for therapeutic injections, such as allergy shots, are covered when you get them in a professional provider's office. When you can get similar results with self-administered medications at home, the administrative services for therapeutic injections by your provider are not covered. Vitamin and mineral injections are not covered unless they are medically necessary to treat a specific medical condition. More information is in sections 7.4.23 and 7.6.6.

7.4.33 Therapeutic Radiology and Chemotherapy

Covered expenses include:

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

7.4.34 Transplants

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

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

We cover medically necessary transplants that follow standard medical practice and are not experimental or investigational. Your provider should get prior authorization as soon as possible after you know you may be a possible transplant candidate. This section's requirements do not apply to collecting and/or transfusing blood or blood products (see section 7.4.32).

Benefits for transplants are limited as follows:

- a. If a transplant procedure is performed at a facility other than a Center of Excellence, the deductible and coinsurance will not accumulate toward the out-of-pocket maximum amount. **Note:** Your coinsurance will apply to services not performed at a Center of Excellence even if you have met the out-of-pocket maximum.
- b. Donor costs are covered as follows:
 - i. If you are the recipient or self-donor, donor costs related to a covered transplant are covered. If the donor is also enrolled in this Plan, expenses resulting from complications and unforeseen effects of the donation are covered.
 - ii. If you are the donor and the recipient is not enrolled in this Plan, we will not pay any benefits toward donor costs.
 - iii. If the donor is not enrolled in this Plan, expenses that result from complications and unforeseen effects of the donation are not covered.
- c. Travel and housing expenses for the recipient and one caregiver are covered up to a maximum per transplant.
- d. Professional provider transplant services are paid according to the benefits for professional providers.
- e. Immunosuppressive drugs you get during a hospital stay are paid as a medical supply. Outpatient oral and self-injectable prescription medications for transplant related services are paid under the Pharmacy Prescription benefit (section 0).
- f. We will not pay for chemotherapy with autologous or homogenic/allogenic bone marrow transplant for treatment of any type of cancer not approved for coverage.

A center of excellence is a facility and/or team of professional providers that we have agreements with to provide transplant services. Centers of excellence follow best practices and have exceptional skills and expertise in managing patients with a specific condition.

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

7.4.35 Virtual Care Visits (Telemedicine)

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

A virtual care visit is covered if:

- a. The covered service can be safely and effectively provided in a virtual care visit
- b. The technology used meets all state and federal standards for privacy and security of protected health information

Virtual care visits using the preferred vendor are covered at no cost sharing (see Section 3). You may not have to pay anything for some visits with your PCP (see Section 3).

7.4.36 Pediatric Vision Services

If you are under age 19, we cover the following services once per year. This coverage ends at the end of the month in which you reach age 19.

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

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

If you are eligible for vision plan benefits, VSP will provide benefit authorization directly to the in-network doctor. When contacting an in-network doctor directly, you must identify yourself as a VSP member so the doctor will obtain benefit authorization from VSP. If you receive services from an in-network doctor without such benefit authorization or obtain services from an out-of-network provider, you are responsible for payment in full to the provider and will need to submit a request for reimbursement by completing the member reimbursement claim form, which is available by visiting www.vsp.com or calling 800-877-7195. Payment in these instances is limited to those for an out-of-network provider.

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

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

7.5 MATERNITY CARE

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

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

If you have a home birth, the only expenses that are covered are the fees billed by a professional provider. Other home birth charges, such as travel and portable hot tubs, are not covered.

Supportive services, such as physical, emotional and information support to you before, during and after birth and during the postpartum period, are not covered expenses.

7.5.1 Breastfeeding Support

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

7.5.2 Circumcision

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

7.5.3 Diagnostic Procedures

Diagnostic services, including laboratory tests and ultrasounds, related to maternity care are covered. Some of these procedures may need to be prior authorized. A full list of services that must be prior authorized is on the Moda Health website, or you may ask Customer Service.

7.5.4 Involuntary Complications of Pregnancy

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

7.5.5 Office, Home or Hospital Visits

A visit means you are actually examined by a professional provider for pregnancy care and childbirth visits.

7.5.6 Hospital Benefits

Covered hospital maternity care expenses are:

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

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

Benefits for any hospital length of stay related to childbirth will not be restricted to less than 48 hours after a normal vaginal delivery or 96 hours after a cesarean section. You may go home earlier if you want to. The attending professional provider for you and your baby will make this decision with you. You do not need a prior authorization to stay in the hospital up to these limits.

7.6 PHARMACY PRESCRIPTION BENEFIT

Prescription medications you get when you are admitted to the hospital are covered by the medical plan as part of your inpatient expense. The prescription medications benefit described here does not apply. All medications must be medically necessary to be covered.

7.6.1 Definitions

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

Formulary is a list of all prescription medications and how they are covered under the pharmacy prescription benefit. Use the prescription price check tool on your Member Dashboard to get coverage information, treatment options and price estimates.

Generic Medications are medications that have been found by the Food and Drug Administration (FDA) to be therapeutically equivalent to the brand option and will often save you money. Generic medications must have the same active ingredients as the brand version and be identical in strength, dosage form and the way you take them.

Nonpreferred Tier Medications are brand medications, including specialty brand medications, that we have reviewed and find they do not have significant therapeutic advantage over their preferred alternative(s). These medications generally have safe and effective options available under the Value, Select and/or Preferred tiers.

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

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

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

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

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

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

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

Self-Administered Medications are labeled by the FDA for self-administration. You or your caregiver can safely administer these medications to you outside of a medical setting (such as a physician's office, infusion center or hospital).

Specialty Medications Specialty medications are often used to treat complex chronic health conditions. Specialty medications often require special handling and have a unique ordering process. Most specialty medications must be prior authorized.

Value Tier Medications include commonly prescribed medications used to treat chronic medical conditions. They are considered safe, effective and cost-effective compared to other medication options. A list of value tier medications is on your Member Dashboard.

7.6.2 Covered Medication Supply

These medications and supplies are covered when they have been prescribed for you:

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

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

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

You or your professional provider can ask for a medication that is not on the formulary through your Member Dashboard or by contacting Customer Service. Formulary exceptions must be based on medical necessity. We will need your prescribing professional provider's contact information and information from your provider to support the medical necessity, including all of the following:

- a. You tried the formulary medications, using the right dose and for a long enough time, and they did not work for you

- b. You were not able to tolerate the formulary medications, or they were not effective for you
- c. The formulary medications are expected to be harmful to you or not give the same result as the medication you are asking for
- d. The medication treatment you are asking for is not experimental or investigational

We will contact your prescribing professional provider to find out how the medication is being used in your treatment plan. We will make a decision about your exception request within 72 hours – or just 24 hours if your request is urgent. This formulary exception process is not used for a medication or pharmacy charge that is not covered for other reasons, such as plan limitations or exclusions.

7.6.3 90-Day Supply at Participating Retail Pharmacies

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

7.6.4 Mail Order Pharmacy

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

7.6.5 Specialty Services & Pharmacy

Specialty medications are often used to treat complex chronic health conditions. Your pharmacist and other professional providers will tell you if your prescription must be prior authorized or if you must get it from a specialty pharmacy. Find out about the clinical services and if your medication is a specialty medication on your Member Dashboard or by asking Customer Service.

Most specialty medications must be prior authorized. If you buy specialty medications at a non-Moda-designated specialty pharmacy, prior authorization is required. Some specialty prescriptions may be limited to less than 30 days. Some medications may be eligible for a 90-day supply. For some specialty medications, you may have to enroll in a program to make sure you know how to use the medication correctly and/or to lower the cost of the medication. Get more information on your Member Dashboard or by asking Customer Service.

7.6.6 Self-Administered Medication

All self-administered medications follow all of the prescription medication requirements of section 0. This includes specialty medication requirements (section 7.6.5) when you get a self-administered specialty medication. Self-administered injectable medications are not covered if you get them in a provider’s office, clinic or facility.

7.6.7 Step Therapy

When a medication is part of the step therapy program, you must try certain medications (Step 1) before the prescribed Step 2 medication will be covered. When a prescription for a step

therapy medication is submitted out of order, meaning you have not first tried the Step 1 medication before submitting a prescription for a Step 2 medication, the prescription will not be covered. When this happens, your provider will need to prescribe the Step 1 medication.

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

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

7.6.8 Limitations

- a. New FDA approved medications will be reviewed. We may have coverage requirements or limits. You or your prescriber can ask for a medical necessity evaluation if we do not cover a newly approved medication during the review period.
- b. You will need a formulary exception to use a brand medication when a generic equivalent is available. If the exception request is approved, you will have to pay the difference in cost between the generic and brand medication. These additional costs do not count toward your out-of-pocket maximum.
- c. We may prior authorize certain brand medications for a specific amount of time or until a generic medication becomes available, whichever comes first. When a generic medication becomes available during the authorized period, the brand medication is no longer covered. You can get the generic medication without a new prescription or authorization.
- d. You may not bypass this Plan's requirements (such as step therapy, prior authorization) by starting treatment with a medication, whether by using free samples or otherwise.
- e. Some specialty medications may be limited to a 2-week supply.
- f. Medications with dosing intervals greater than this Plan's maximum day supply will have an increased copayment to match the day supply.
- g. Medications you buy outside the United States and its territories are only covered in emergency and urgent care situations.
- h. You may ask to have your medication refilled early if you are going to travel outside of the United States. When we allow an early refill, it is limited to once every 6 months. You cannot get an early refill to extend your medication supply beyond the end of the plan year.

7.6.9 Exclusions

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

- a. **Devices.** Including, but not limited to therapeutic devices and appliances. Information for contraceptive devices is in section 7.6.2 and for other devices in section 7.4.11
- b. **Foreign Medication Claims.** Medications you buy from non-U.S. mail order or online pharmacies or U.S. mail or online pharmacies acting as agents of non-U.S. pharmacies
- c. **Hair Growth Medications.**
- d. **Immunization Agents for Travel.** Except as required under the Affordable Care Act
- e. **Institutional Medications.** To be taken by or administered while you are a patient in a hospital, rest home, skilled nursing facility, extended care facility, nursing home or similar institution
- f. **Medication Administration.** A charge to administer or inject a medication, except for immunizations or contraceptives at retail pharmacies
- g. **Medications Covered Under Another Benefit.** Such as medications covered under home health, medical, etc.

- h. **Medications Not Approved by FDA.** Products not recognized or designated as FDA approved medications. This includes medications that are found to be less than effective by the FDA's Drug Efficacy Study Implementation (DESI) classifications.
- i. **Non-Covered Condition.** A medication prescribed for reasons other than to treat a covered medical condition
- j. **Nutritional Supplements and Medical Foods.**
- k. **Off-label Use.** Medications prescribed for or used for non-FDA approved indications, unless confirmed by other research studies, reference, compendium, or the federal government
- l. **Over the Counter (OTC) Medications** and certain prescription medications that have an OTC option, except for contraceptives or those treating tobacco dependence
- m. **Pharmacies Excluded from the Network.** Medications from pharmacies that have been excluded from the network for non-compliance with fraud, waste or abuse laws.
- n. **Repackaged Medications.**
- o. **Replacement Medications and/or Supplies.**
- p. **Vitamins and Minerals.** Except as required by law
- q. **Weight Loss Medications**

SECTION 8. GENERAL EXCLUSIONS

This section lists Plan exclusions. These are in addition to the limitations and exclusions that are described in other sections. These services, supplies and conditions are not covered, even if they are medically necessary, are recommended or provided by a professional provider, or they relate to a covered condition. Treatment of a complication or consequence that happens because of an exclusion is not covered. Except, treatment of an emergency medical condition is always covered.

Abortion

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

Benefits Not Stated

Services and supplies not specifically described in this handbook as covered expenses, unless required under federal or state law.

Care Outside the United States

Except for care that is due to an urgent or emergency medical condition.

Charges Over the Maximum Plan Allowance

Except when required under this Plan's coordination of benefits rules (see section 9.6.1).

Cosmetic Procedures

Any procedure or medication with the main purpose of changing or maintaining your appearance and that will not result in significant improvement in body function. Examples include rhinoplasty, breast enhancement, liposuction and hair removal. Reconstructive or gender affirming surgery is covered if medically necessary and not specifically excluded (see sections 7.4.32 and 7.4.13).

Court Ordered Sex Offender Treatment

Custodial Care

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

Dental Examinations and Treatment; Orthodontia

Except services described in section 7.4.8

Educational Supplies and Services

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

- a. Books, tapes, pamphlets, subscriptions, videos and computer programs (software)
- b. Psychoanalysis or psychotherapy as part of a training or educational program, regardless of your diagnosis or symptoms

Experimental or Investigational Procedures

Expenses due to experimental or investigational procedures. Includes related expenses, even if they would be covered in other (non-experimental, non-investigational) situations (see definition of experimental/investigational in Section 12).

Faith Healing**Food Services**

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

Home Birth or Delivery

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

Homeopathic Treatment and Supplies**Horse-Assisted or Animal Therapy****Illegal Acts**

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

Infertility

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

Inmates

Services and supplies you get while you are in the custody of any state or federal law enforcement authorities or while in jail or prison.

Massage or Massage Therapy**Missed Appointments****Naturopathic Supplies**

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

Never Events

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

Non-Therapeutic Counseling

Including legal, financial, vocational, spiritual and pastoral counseling.

Nuclear Radiation

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

Nutritional Counseling

Except as described in section 0.

Obesity or Weight Reduction

Even if you are morbidly obese. Services and supplies including:

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

This Plan covers services and supplies that are necessary to treat established medical conditions that may be caused by or made worse by obesity. Services and supplies that do so by treating the obesity directly are not covered, except as required under the Affordable Care Act.

Orthopedic Shoes

Except as described in section 7.4.11.

Orthognathic Surgery

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

Personal Items

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

Physical Exercise Programs

Programs, videos and exercise equipment

Private Nursing Services

Professional Athletic Activities

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

Recreation Related Services and Equipment

Recreation therapy and equipment used mainly in recreational activities

Reports and Records

Including charges for completing claim forms or treatment plans.

Routine Foot Care

Including the following services unless your medical condition (such as diabetes) requires them:

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

School Services

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

Self-Administered Medications

Including oral and self-injectable when you get them directly from a physician's office, facility or clinic instead of through the pharmacy prescription medication or anticancer benefits (sections 7.6.6 and 7.4.3).

Self-Improvement Programs

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

Service Related Conditions

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

Services for Administrative or Qualification Purposes

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

Services Otherwise Available

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

- a. You have not been charged or the charge has been reduced or discounted, or you would not normally be charged if you do not have insurance
- b. Another third party has paid or is obligated to pay, or would have paid if you had applied for the program. This may include coverage under a separate contract that provides coordinated coverage that is considered part of the same plan. It could also be a government program unless prohibited by law.

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

Services Provided or Ordered by a Family Member

Other than services by a dental provider. For the purpose of this exclusion, family members include you and your spouse or domestic partner, child, sibling, or parent, or your spouse's or domestic partner's parent.

Services Provided by Volunteer Workers**Sexual Disorders and Paraphilic Disorders**

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

Support Education

Including:

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

Taxes, Fees and Interest

Except as required by law

Telehealth

Except telemedicine as specifically described in section 7.4.36

Temporomandibular Joint Syndrome (TMJ)

Services and supplies related to the treatment of TMJ.

Therapies

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

Third Party Liability Claims

Services and supplies to treat a medical condition that a third party is or may be responsible for, to the extent of any recovery received from or on behalf of the third party (see 9.6.3).

Transportation

Except medically necessary ambulance transport.

Treatment in the Absence of Illness

Including individual or family counseling or treatment for marital, behavioral, financial, family, occupational or religious problems, treatment for at risk individuals who do not have an illness or a diagnosed mental health condition or substance use disorder, or treatment of normal transitional response to stress.

Treatment After Coverage Ends

The only exceptions are:

- a. You are eligible for an extension of coverage (see sections 11.2 and 11.3)
- b. Covered hearing aids ordered before your coverage ends and you get them no more than 90 days after the end date

Treatment Before Coverage Begins

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

Treatment Not Medically Necessary

Including services or supplies that do not meet our medical necessity criteria or are:

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

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

Vision Care

Including eye exams, the fitting, provision or replacement of eyeglasses or contact lenses, and any charges for orthoptics, vitamin therapy, low vision therapy, eye exercises or fundus photography, except where specifically covered under this Plan. See section 7.4.37 for pediatric vision services and section 7.4.9 for coverage of annual dilated eye exam to manage diabetes.

Vision Surgery

Any procedure to cure or reduce near-sightedness, far-sightedness or astigmatism. Includes reversals or revisions, and treating any complications, of these procedures.

Vitamins and Minerals

Not covered unless required by law or if medically necessary to treat a specific medical condition. Coverage is only under the medical benefit. The vitamin or mineral must require a prescription, and a dosage form of equal or greater strength of the medication is not available without a prescription under federal law. This applies whether the vitamin or mineral is oral, injectable or transdermal. Naturopathic substances are not covered.

Wigs, Toupees, Hair Transplants

Work Related Conditions

Treatment of a medical condition you get because of your employment or self-employment, whether or not the expense is paid under any workers' compensation provision. This exclusion does not apply if you are an owner, partner or executive officer, if you are exempt from workers' compensation laws and the Group does not provide workers' compensation coverage to you.

SECTION 9. CLAIMS ADMINISTRATION & PAYMENT

9.1 SUBMISSION & PAYMENT OF CLAIMS

What to know about sending us a claim:

- a. We must receive your claim (also known as proof of loss) no more than 12 months after the date of service
- b. We will not pay any claims we do not receive on time. The only exceptions are Medicaid claims or absence of legal capacity. Claims from Medicaid must be sent to us no more than one year after the date of service.
- c. We do not always pay claims in the same order you received the services. This may affect how your cost sharing is applied to claims. For example, a deductible may not be applied to the first date you were seen in a benefit year if we pay a later date of service first
- d. We may pay benefits to you, to the provider or to both of you

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

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

9.1.1 How to Send Us Claims

Sometimes you will have to pay a provider up front. If you need to submit claims, you can let us know you have a claim (also known as notice of claim) and we will send you a claim form. You may download a claim form directly from our website.

When you are billed by the hospital or professional provider directly, send us a copy of the bill (see section 2.1). Include all of the following information:

- a. Patient's name, subscriber's name, and group and ID numbers
- b. Date of service
- c. Diagnosis (including the ICD diagnosis codes)
- d. Itemized description of the services and charges (including the CPT or HCPCS procedure codes)
- e. Provider's tax ID number
- f. Proof of payment. This can be a credit card/bank statement or cancelled check

Some claims will require additional information:

- a. **Accidental injury:** include the date, time, place and description of the accident
- b. **Ambulance service:** include where you were picked up and where you were taken
- c. **Vision service:** a member who has vision services provided by an in-network provider without benefit authorization will need to submit a request for reimbursement by completing the member reimbursement claim form, which is available by visiting www.vsp.com or calling 800-877-7195

- d. **Out-of-country care:** Only covered when you have an emergency or need urgent care. When you get care outside the United States, include:
 - i. Explanation of where you were and why you needed care
 - ii. Copy of the medical record (translated if available)
 - iii. Proof of payment. This can be a credit card/bank statement or cancelled check

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

9.1.2 Prescription Medication Claims

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

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

9.1.3 Explanation of Benefits (EOB)

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

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

9.1.4 Claim Inquiries

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

9.1.5 Time Frames for Processing Claims

You will hear from us no more than 30 days after we receive a claim.

- a. If the claim is denied, we will send an EOB explaining the denial
- b. If we need more information, the notice of delay will describe the information we need. Whoever is responsible for providing the additional information will have 45 days to send it to us. We will finish processing the claim no more than 15 days after we get the additional information

We must receive all of information we need to process your claim within this Plan's claim submission period explained in section 9.1.

9.2 COMPLAINTS, APPEALS & EXTERNAL REVIEW

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

9.2.1 Time Limit for Submitting Appeals

If your appeals are not on time, you will lose the right to any appeal.

- a. You have **180 days** from the date you receive an adverse benefit determination to send us your first level appeal
- b. You have **60 days** from the date of the first level appeal decision to send us your second level appeal

You can fill out an appeal form (in your Member Dashboard under Resources), or send us a letter including all of the identifying information from the appeal form (see “If I am not satisfied...” in section 13.1). Describe what happened and what outcome you are hoping for. Including medical records or other documentation that will help us investigate your appeal.

9.2.2 The Review Process

This Plan has a 2-level internal review process, a first level appeal and a second level appeal. If you are not satisfied with the result of the second level appeal, you may ask for external review by an independent review organization. You must finish the first and second levels of appeal before you can ask for external review, unless we agree to skip the internal reviews.

You may review the claim file and submit written comments, documents, records and other information to support your appeal. You may choose a person (representative) to act on your behalf. You must sign an authorization to disclose protected health information (PHI) allowing your representative to act for you. You also have the right to appeal before a panel via virtual meeting. You may find this form on modahealth.com. Contact Customer Service for help assigning your representative.

How First and Second Level Appeals Work

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

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

Expedited Appeals

Appeals can have a faster review upon request. Review of appeals that meet the criteria to be expedited will be finished within 72 hours in total for the first and second level appeals combined after we have received those appeals. The time between the first level appeal decision and when we receive the second level appeal does not count.

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

Special Circumstances

If the appeal is about ending or reducing an ongoing course of treatment before the end of the authorized period of time or number of treatments, we will continue to provide benefits while

we review your appeal. If the decision is upheld, you will have to pay back the cost of the benefits you received during the review period.

The timelines for reviewing your appeal do not apply if:

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

If this is an ERISA plan, you must go through the first and second levels of appeal before you can sue under ERISA section 502(a). You may lose the right to sue if you have not used all of your internal appeal rights. The only exception is if we do not meet the timelines for review or provide all of the information and notices required under state and federal law. Ask your employer if this Plan is subject to ERISA.

9.2.3 External Review

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

YOUR RIGHT TO AN INDEPENDENT EXTERNAL REVIEW

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

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

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

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

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

Idaho Department of Insurance
ATTN: External Review
700 W State St., 3rd Floor

Boise ID 83720-0043

For more information and for an external review request form:

See the department's website at <http://www.doi.idaho.gov>, or

Call the department's telephone number, 208 334-4250, or toll-free in Idaho, 1-800-721-3272.

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

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

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

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

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

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

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

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

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

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

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

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

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

9.2.4 Complaints

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

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

We will finish reviewing your complaint within 30 days. If we need more time, we will send you a letter letting you know about the delay. We will have 15 more days to make a decision.

9.2.6 Additional Member Rights

You have the right to file a complaint or ask for help from the Idaho Department of Insurance.

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

9.2.7 Definitions

For purposes of section 9.2, the following definitions apply:

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

- a. Rescission of coverage (section 10.5.6)
- b. Eligibility to participate in this Plan
- c. Network exclusion, annual benefit limit or other limitation on otherwise covered services
- d. Utilization review (described below)
- e. Limitations or exclusions described in Section 7 and Section 8, including a decision that an item or service is experimental or investigational or not medically necessary

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

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

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

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

- a. Seriously risk your life or health or ability to regain maximum function
- b. Would subject you to severe pain that cannot be managed without the requested care or treatment. A physician with knowledge of your medical condition decides this

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

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

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

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

9.4 CONTINUITY OF CARE

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

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

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

Continuing care patients mean persons who meet one of the following:

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

In addition:

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

Continuity of care ends on the earlier of the following dates:

- a. 90 days starting on the date we send you a letter about your right to continuity of care
- b. the date on which you are no longer a continuing care patient with the provider

Continuity of care is not available if:

- a. You leave this Plan
- b. The Group ends this Plan
- c. The provider has moved out of the service area
- d. The provider cannot continue to care for patients for other reasons
- e. The contract with the provider ended for reasons related to quality of care and they have finished any appeals process

9.6 BENEFITS AVAILABLE FROM OTHER SOURCES

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

9.6.1 Coordination of Benefits (COB)

Coordination of benefits applies when you have healthcare coverage under more than one plan. If you are covered by another plan or plans, the benefits under this Plan and the other plan(s) will be coordinated. This means one plan pays its full benefits first, and then any other plans pay. This Plan follows the order of benefit determination rules in the Idaho Administrative Procedures Act. These rules decide which plan is primary and pays a claim for benefits first. (For coordination with Medicare, see section 9.6.2.)

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

9.6.1.1 When this Plan Pays First

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

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

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

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

9.6.1.2 How COB Works

When we are the primary plan, we will pay benefits as if there was not any other coverage.

If we are the secondary plan, the primary plan will pay its full benefits first. We will need a copy of your primary plan's EOB so we can see what they paid. If there are covered expenses that the primary plan has not paid, such as deductibles, copayments or coinsurance, we may pay some or all of those expenses.

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

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

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

9.6.1.3 Definitions

For purposes of section 9.6.1 the following definitions apply:

Allowable expense means a healthcare expense, including cost sharing, that is covered at least in part by any plan you have coverage under. When a plan provides benefits in the form of a service instead of cash payments, the reasonable cash value of the service is considered an allowable expense and a benefit paid.

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

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

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

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

Plan is any of the following that provide benefits or services for medical or dental care or treatment.

- a. Group or nongroup insurance contracts and subscriber contracts
- b. HMO (health maintenance organization) coverage

- c. Closed panel plans
- d. Medical benefits under group or individual automobile contracts
- e. Medical care components of group long-term care contracts, such as skilled nursing care
- f. Medicare or other government programs, other than Medicaid, and any other coverage required or provided by law
- g. Other arrangements of insured or uninsured group or group-type coverage

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

If separate contracts are used to provide coordinated coverage for covered persons in a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

Plan does not include:

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

9.6.2 Coordination with Medicare

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

9.6.3 Third Party Liability

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

This Plan does not cover benefits when someone else - a third party - is legally responsible. This may include a person, a company or an insurer. Recovery from a third party may be difficult and take a long time, so we will pay your expenses based on your understanding and agreement that we are entitled to be reimbursed for any benefits paid that are or may be recoverable from a third party. You agree to do whatever is necessary to fully secure and protect our right of recovery or subrogation. Subrogation refers to substituting one party for another in a legal setting. We are entitled to all subrogation rights and remedies under common and statutory law, as well as under this Plan.

You will cooperate with us to protect our subrogation and recovery rights. This includes signing and delivering any documents we reasonably require to protect our rights and providing any information or taking actions that will help us recover costs from a third party.

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

- b. We are entitled to be reimbursed for any benefits this Plan pays out of any recovery from a third party if there is a settlement or judgment against the third party. This is so whether or not the third party admits liability or claims that you are also at fault. We are entitled to receive the amount of benefits this Plan has paid whether the healthcare expenses are itemized or expressly excluded in the third party recovery.
- c. If this Plan is subject to ERISA, it is not responsible for and will not pay any fees or costs (such as attorney fees) associated with your pursuing a claim against a third party. Neither the “made whole” rule nor the “common fund doctrine” rule applies. If this Plan is exempt from ERISA, a proportionate share of reasonable attorney fees may be subtracted from our recovery.
- d. Even without your written authorization, we may release to, or obtain from, any other insurer, organization or person, any information we need to carry out the provisions of section 9.6.3.
- e. If it is reasonable to expect that you will have future expenses for which this Plan might pay benefits, you will seek recovery of such future expenses in any third party claim.
- f. Section 9.6.3 applies to you if this Plan advances benefits whether or not the event causing your injuries occurred before you became covered by Moda Health.

If you or your representatives do not comply with the requirements of this section, then we may not advance payment or may suspend payment of any benefits, or recover any benefits we have advanced, for any medical condition related to the third party claim. We may notify medical providers seeking payment that all payments have been suspended and may not be paid.

9.6.4 Surrogacy

If you enter into a surrogacy agreement, you must reimburse this Plan for covered services related to conception, pregnancy, delivery and postpartum care that you receive in connection with the surrogacy agreement. By accepting services, you give us the right to receive payments you receive or are entitled to receive under the surrogacy agreement. Within 30 days after entering a surrogacy agreement, you must inform us and send us a copy of the agreement.

SECTION 10. ELIGIBILITY & ENROLLMENT

For coverage to become effective, you must submit an application on time. Any necessary premiums must also be paid.

10.1 SUBSCRIBER

You must give the Group a complete and signed application for yourself and any dependents to be enrolled within 31 days of becoming eligible to apply for coverage.

Your coverage begins on the date specified in the policy. This will be on your enrollment date or after a waiting period.

To stay covered by this Plan, you must work the required hours. If your job changes, this could affect your eligibility.

You must tell us and the Group if your address changes.

10.2 DEPENDENTS

A subscriber's legal spouse or domestic partner (as defined in Section 12) is eligible for coverage. If a subscriber marries or enters a domestic partnership, the spouse or domestic partner and their children can enroll as of the date of the marriage or partnership. Coverage begins on the first day of the month after your application is received. See section 10.4 for more information.

A subscriber's children are eligible until their 26th birthday. The age limit applies even if a court or administrative order requires you to provide coverage after age 26.

In this Plan, eligible children are:

- a. The biological or adopted child of the subscriber or the subscriber's eligible spouse or domestic partner
- b. Children placed for adoption with the subscriber or the subscriber's eligible spouse or domestic partner
- c. The subscriber's newborn child for the first 31 days of the newborn's life
- d. Children related to the subscriber and the subscriber is their legal guardian

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

Children with Disabilities

A subscriber's unmarried child who has a disability that makes them physically or mentally incapable of self-support is eligible for coverage even when they are over 26 years old. Submit written information from the child's physician showing that the child has an ongoing disability

that does not allow them to work to support themselves. To make sure there is not a gap in coverage, we need this information at least 45 days before their 26th birthday. We may ask for more information, such as tax and guardianship information, to confirm the child is eligible for this extended coverage. We will review eligibility from time to time unless the disability is permanent.

10.2.1 New Dependents

A new dependent may cause your premium to go up. Any premium changes will apply from the date coverage is effective. If you do not submit an application and/or payment when required, the new dependent will not be covered. The Group will tell you if your premium is changed and how much you owe. You must pay the new amount at your next premium payment.

To add a new dependent to your coverage, submit:

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

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

10.3 OPEN ENROLLMENT

If you are not enrolled within the required time when first becoming eligible, you must wait for the next open enrollment period to enroll unless:

- a. You qualify for special enrollment as described in section 10.4
- b. A court has ordered you to provide coverage for a spouse or minor child under the subscriber's health benefit plan. You must enroll no more than 30 days after the court order is issued

Open enrollment occurs once a year at renewal. If you enroll during open enrollment, coverage begins on the date this Plan renews.

10.4 SPECIAL ENROLLMENT

If you lose other coverage or become eligible for a premium assistance subsidy, you have special enrollment rights. Special enrollment applies to both the eligible employee and their dependent if neither is enrolled under this Plan, and either loses other coverage or becomes eligible for a premium assistance subsidy.

To enroll, an eligible employee must submit a complete and signed application and supporting documentation within the required timeframe.

10.4.2 Loss of Other Coverage

If you do not enroll in this Plan when you are first eligible or at open enrollment because you have other health coverage, you may be able to enroll outside of the open enrollment period. You must meet all of the following criteria:

- a. You stated in writing that you already had health coverage when this Plan was first offered to you
- b. You ask to enroll no more than 31 days after your prior coverage ended
- c. You have a qualifying event. These are:
 - i. Your other coverage ended because you were no longer eligible. Examples of when this may happen include:
 - A. loss of dependent status per plan terms, including divorce or legal separation
 - B. end of employment or not working enough hours
 - C. the plan stops offering coverage to a specific group of similarly situated persons
 - D. moving out of an HMO service area and the plan does not have another option
 - E. the benefit package option is canceled, and no substitute option is offered
 - ii. You were covered under Medicaid or a children's health insurance program (CHIP) and the coverage ended due to loss of eligibility. You have up to 60 days after the end of coverage to enroll
 - iii. You exhausted your COBRA continuation coverage

Coverage begins on the first day of the month after the special enrollment request is received, or coinciding with, but not before, the loss of other coverage.

10.4.3 Payment Changes

You may have special enrollment rights when there are changes in how your premiums are paid:

- a. Employer premium contributions toward your other active coverage (not COBRA coverage) ends. You must ask for special enrollment no more than 31 days after the premium contributions end.
- b. If you are covered under Medicaid or CHIP and become eligible for a premium assistance subsidy, you may enroll in this Plan outside of the open enrollment period. You must ask for special enrollment no more than 60 days of becoming eligible.

Coverage begins on the first day of the month after the special enrollment request is received, or coinciding with, but not before, the premium contribution or subsidy change.

10.4.4 Gaining New Dependents

The employee has special enrollment rights if they are not enrolled at the time of the event that caused them to gain a new dependent (such as marriage, domestic partnership, birth, adoption or placement for adoption). You can enroll along with your new dependent. See section 10.2.1.

10.4.5 Qualified Medical Child Support Order (QMCSO)

The child of an eligible employee may have a right to enroll because of a qualified medical child support order (QMCSO). You may get a copy of the detailed procedures used to decide if an order qualifies as a QMCSO from the Group at no cost. Coverage begins on the first day of the month after the date the Group decides the order qualifies as a QMCSO and that the child is eligible to enroll in this Plan.

10.5 WHEN COVERAGE ENDS

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

10.5.1 The Group Plan Ends

Coverage ends for the Group as a whole and members on the date this Plan ends.

10.5.2 Subscriber Ends Coverage

A subscriber may end their coverage, or coverage for any enrolled dependent, only at open enrollment or if there is a qualifying event. Qualifying events include marriage, divorce and birth. Coverage ends on the last day of the month through which premiums are paid.

10.5.3 Death

If a subscriber dies, coverage for any enrolled dependents ends on the last day of that month. You may extend your coverage if you meet the requirements for continuation of coverage (see Section 11). The Group must tell us your coverage is continued, and include your continuation premiums along with their regular monthly payment.

10.5.4 Termination, Layoff or Reduction in Hours of Employment

When your employment ends, coverage ends on the last day of that month, unless you choose to continue coverage (see Section 11).

If you are laid off work or your hours are reduced, coverage ends on the last day of the month you were eligible.

10.5.5 Loss of Eligibility by Dependent

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

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

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

Enrolled dependents may have the right to continue coverage in their own names when their coverage under this Plan ends (see Section 11).

10.5.6 Rescission

Rescission means cancelling (rescinding) coverage back to the effective date, as if it had not existed. We may rescind your coverage, or deny claims at any time, for fraud or intentional material misrepresentation by you or the Group. Examples of fraud and material misrepresentation include but are not limited to:

- a. Enrolling someone who is not eligible
- b. Giving false information or withholding information that is the basis for eligibility or employment

c. Submitting false or altered claims

We have the right to keep any premiums paid as liquidated damages. You and/or the Group will have to repay any benefits that have been paid. We will tell you of a rescission 30 days before your coverage is canceled.

10.6 ELIGIBILITY AUDIT

We have the right to make sure you are eligible. We may ask for documentation including but not limited member birth certificates, adoption paperwork, marriage or domestic partnership documentation and any other evidence necessary to document your eligibility for this Plan.

SECTION 11. CONTINUATION OF HEALTH COVERAGE

Check with the Group to find out if you qualify for continuation coverage. You should read the following sections carefully.

11.1 COBRA CONTINUATION COVERAGE

COBRA continuation coverage does not apply to all groups. Check with the Group to find out if this Plan qualifies. In this COBRA section, COBRA Administrator means either the Group or the third party administrator they have assigned to handle COBRA administration. Your coverage under COBRA continuation will be the same as that for other members under this Plan.

You may elect COBRA if you are the subscriber and you lose coverage because your employment ended (other than for gross misconduct), or your hours are reduced. Be sure to look at *Special Circumstances at the end of the COBRA section.

If you are the spouse or child of a subscriber, COBRA is available if you lose coverage because of:

- a. The subscriber's death
- b. The subscriber's employment ends (other than for gross misconduct) or their hours of employment with the Group are reduced
- c. The subscriber becomes entitled to Medicare
- d. Divorce or legal separation from the subscriber*
- e. You no longer meet the definition of "child" under this Plan

You must provide written notice to the COBRA Administrator if one of these events occurs. Include: 1) the name of the Group; 2) the name and social security number of the affected members; 3) the event (e.g., divorce); and 4) the date the event occurred. You must give notice no later than 60 days after you lose coverage under this Plan. If notice of the event is not given on time, COBRA is not available.

Electing COBRA. You must elect COBRA within 60 days after plan coverage ends, or, if later, 60 days after the COBRA Administrator sends you notice of your right to elect COBRA. Each family member* has an independent right to elect COBRA coverage. This means that a spouse or child may elect COBRA even if the subscriber does not.

You are responsible for all COBRA premiums. Due to the 60-day election period, you will owe retroactive premiums for the months between when regular coverage ended and the first payment date. You must pay these premiums in a lump sum at the first payment. The first payment is due within 45 days after you elect coverage (this is the date the election notice is postmarked, if mailed, or the date the COBRA Administrator receives it, if hand-delivered). The premium rate may include a 2% add-on to cover administrative expenses.

All other payments are due on the 1st of the month. You will not receive a bill. You are responsible for paying your premiums when due. If your premiums are not received on time, your COBRA coverage will end and may not be reinstated. You will have a 30-day grace period to pay the premiums.

Length of COBRA

COBRA due to end of employment or a reduction of hours of employment generally lasts up to 18 months. COBRA because of a subscriber's death, divorce or legal separation, or a child ceasing to be a dependent under the terms of this Plan, can last up to a total of 36 months.

If the subscriber became entitled to Medicare less than 18 months before their employment ends or their hours are reduced, COBRA for members (other than the subscriber) who lose coverage because of the employment end/reduction in hours can last up to 36 months after the date of Medicare entitlement.

You and your family may be eligible for a longer period of COBRA coverage if you are disabled or a second qualifying event occurs. You must notify the COBRA Administrator within 60 days of a second qualifying event or becoming disabled. If you do not, you will lose the right to extended COBRA coverage.

If the Social Security Administration determines you are disabled, your 18-month COBRA period may be extended to a total of up to 29 months. The disability must have started before the 61st day of your COBRA coverage period. The Social Security Administration must make its decision before the end of your initial 18-month COBRA period.

You must give a copy of the Social Security Administration's determination of disability to the COBRA Administrator no more than 60 days after the latest of:

- a. the date of the Social Security Administration's disability determination
- b. the date of the subscriber's termination of employment or reduction of hours
- c. the date on which you lose (or would lose) coverage under the terms of this Plan as a result of the subscriber's termination or reduction of hours of employment

Each family member on COBRA can have the disability extension if one of you qualifies. Your COBRA premiums may increase after the 18th month of coverage to 10% of the premiums. Your disability extension ends if you are no longer considered disabled

If you are a spouse or child on COBRA and a second qualifying event occurs, your maximum COBRA period may be extended to 36 months from the date of the first qualifying event. Second qualifying events may include the death of the subscriber, divorce or legal separation from the subscriber, or a child's no longer being eligible as a dependent under this Plan. These are a second qualifying event only if they would have caused you to lose coverage if the first qualifying event had not occurred.

When COBRA Ends. COBRA coverage ends after the maximum COBRA period. It will end earlier if your premiums are not paid on time or the Group stops offering any group health plan to its employees. COBRA will also end if:

- a. You become covered under another group health plan
- b. You become entitled to Medicare benefits after electing COBRA (unless the qualifying event is the Group's bankruptcy)
- c. Any reason this Plan would end coverage if you were not on COBRA (such as fraud)

Ask the COBRA Administrator if you have any questions about COBRA. Don't forget to tell the COBRA Administrator if your address changes.

***Special Circumstances**

A domestic partner does not have an independent election right under COBRA. If you are a covered domestic partner at the time of the qualifying event, the subscriber can include coverage for you when they elect COBRA. Your coverage ends when the subscriber's COBRA coverage ends (for example, due to the subscriber's death or because the subscriber becomes covered under another plan).

Divorce or legal separation may be a qualifying event even if the subscriber ended your coverage earlier. If you notify the COBRA Administrator within 60 days of the divorce or legal separation, COBRA may be available for the period after the divorce or legal separation.

If this Plan provides retiree coverage and the subscriber's former employer files for bankruptcy, this may be a qualifying event if you lose coverage as a result. Contact the COBRA Administrator for more information about this situation.

11.2 TOTAL DISABILITY EXTENSION

When the group policy ends, your coverage may be extended for 12 months if you have total disability:

Total disability means:

- a. You are not able to perform the substantial duties of any occupation or business for which you are qualified by reason of education, training or experience.
- b. You are not engaged in any occupation for wage or profit at the time of being totally disabled.
- c. For dependent children, you are not able to engage in normal duties or activities of a person in good health who is the same gender or age.
- d. You remain as totally disabled during the 12-month extension.

11.3 PREGNANCY EXTENSION

If you are pregnant when the group policy ends and you are not eligible for any replacement group coverage within 60 days of the termination of the group policy, we will provide benefits for pregnancy, childbirth or miscarriage as described in section 7.5 for a 12-month extension from the date of termination.

11.4 OTHER INDIVIDUAL COVERAGE OPTIONS

When your coverage under this plan ends, you may be eligible for COBRA. We also offer individual health policies and Medicare Supplement as additional options or if your group does not have COBRA. Contact Customer Service for more info.

11.6 UNIFORMED SERVICES EMPLOYMENT & REEMPLOYMENT RIGHTS ACT (USERRA)

If the subscriber is called to active duty by any of the armed forces of the United States of America, they may continue coverage under USERRA for up to 24 months or the period of uniformed service leave, whichever is shortest. You must continue to pay your share of the premiums during the leave.

If you do not elect continue coverage under USERRA, or you cancel or use up your USERRA continuation, coverage restarts on the day your return to active employment with the Group. All plan provisions and limitations apply as if your Plan coverage had been continuous. You must be released under honorable conditions, and return to active employment within the required timeframe. You can get complete information about your rights under USERRA from the Group.

11.7 FAMILY & MEDICAL LEAVE

You will remain eligible for coverage during a leave of absence under state or federal family and medical leave laws. If you choose not to stay enrolled, you will be eligible to re-enroll in this Plan on the date the subscriber returns to work. Submit a complete and signed application within 60 days of the return to work. Your coverage will re-start as if there had been no break in coverage.

SECTION 12. DEFINITIONS

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

Authorization see Prior Authorization.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Emergency Medical Condition is a medical condition with acute symptoms, including severe pain, that a prudent layperson with an average knowledge of health and medicine could reasonably expect would place the health of a member, or a fetus in the case of a pregnant member, in serious jeopardy without immediate medical attention.

Emergency Medical Screening Examination is the medical history, examination, related tests and medical determinations required to confirm the nature and extent of an emergency medical condition.

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

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

Enroll means to become covered for benefits under this Plan. You are enrolled when your coverage becomes effective, not at the time you have completed or filed any enrollment forms needed to become covered. You are enrolled in this Plan whether you elect coverage, you are a dependent who becomes covered as a result of an election by the subscriber, or you become covered without an election.

Enrollment Date is, for new hires and others who enroll when first eligible, the date coverage begins or, if earlier, the first day of the waiting period. For all others, the enrollment date is the date the plan coverage actually begins.

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

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

The **Group** is the organization whose employees are covered by this Plan.

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

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

Implant is a material inserted or grafted into tissue.

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

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

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

MPA for out-of-network services is either a supplemental provider fee arrangement we may have in place or the amount calculated using any one of the following methods: a percentage of a Medicare equivalent allowable amount, a percentage of a Medicaid equivalent allowable amount, a percentile of fees commonly charged for a given procedure in a given area, the acquisition cost or a percentage of the billed charge.

MPA for emergency services you get out-of-network, out-of-network air ambulance, or out-of-network services in an in-network facility where you are not able to choose the provider is based on the median in-network rate. Otherwise, the MPA is the amount determined by federal or state guidelines.

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

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

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

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

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

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

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

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

Medically necessary care does not include custodial care.

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

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

Member is a subscriber or dependent of a subscriber who is enrolled for coverage under the terms of this Plan. Where this book refers to "you" or "your" it is referring to a member.

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

- a. Board-certified psychiatrist
- b. Psychologist or psychologist associate
- c. Psychiatric mental health nurse practitioner

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

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

Network is a group of providers who contract to provide healthcare you at negotiated rates. These groups provide in-network services in their specific service areas. See Section 5 for more information about networks. Covered medical expenses will be paid at a higher rate when an in-network provider is used, as shown in Section 3.

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

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

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

This **Plan** is the health benefit plan sponsored by the Group and insured under the terms of the policy between the Group and Moda Health.

Plan Year is the 12 month period starting on the original effective date and each 12 month period afterward.

The **Policy** is the agreement between the Group and Moda Health for insuring the health benefit plan sponsored by the Group. This handbook is a part of the policy.

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

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

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

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

Subscriber is any employee or former employee who is enrolled in this Plan.

Waiting Period is the period that must pass before you are eligible to enroll for benefits under the terms of this Plan.

SECTION 13. GENERAL PROVISIONS & LEGAL NOTICES

13.1 MEMBER DISCLOSURES

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

You have the right to:

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

If I am not satisfied with the plan, how can I file an appeal or complaint?

You can file an appeal or complaint by writing a letter to Moda Health. Include the following information:

- a. Member name and date of birth
- b. Subscriber ID number
- c. Contact information (phone, email, mailing address)
- d. Provider(s) involved
- e. Date(s) of service
- f. Medical records from the provider, if applicable
- g. Reason for the appeal/complaint
- h. Description of what happened
- i. Desired outcome

Customer Service can help you if needed. Complete information about the appeal process is in section 9.2

You have the responsibility to:

- a. Read this handbook and make sure you understand this Plan. You should call Customer Service if you have any questions.
- b. Select a PCP and tell us who you have chosen
- c. To the extent required by this Plan, seek medical services only from their PCP. This includes getting approval from your PCP before going to a specialist
- d. Treat all providers and their staff with courtesy and respect
- e. Be on time for appointments, and call the office ahead of time if you will be late or need to cancel.

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

What additional information about Moda Health is available?

The following documents are available free of charge by calling Customer Service:

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

How can I participate in the development of your corporate policies and practices?

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

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

13.2 GENERAL & MISCELLANEOUS

Contract Provisions

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

Confidentiality of Member Information

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

Right to Collect & Release Needed Information

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

Change of Beneficiary

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

Transfer of Benefits

Only members are entitled to benefits under this Plan. These benefits are not assignable or transferable to anyone else except to the provider.

Correction of Payments or Recovery of Benefits

If Moda Health mistakenly makes a payment for a member to which they are not entitled, or pays a person who is not eligible for payments at all, we have the right to recover the payment from the person paid or anyone else who benefited from it, including a provider. Our right to recovery includes the right to deduct the amount paid from future benefits we would provide for a member even if the mistaken payment was not made on that member's behalf.

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

Warranties

All statements made by the Group 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 Group or the member, a copy of which has been given to the Group or member or the member's beneficiary.

No Waiver

Any waiver of any provision of this Plan or any performance under this Plan 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 Plan, including a delay or omission in denying a claim, that shall not waive Moda Health's rights to enforce the provisions of this Plan.

Group is the Agent

The Group is the members' agent for all purposes under this Plan. The Group is not the agent of Moda Health.

Responsibility for Quality of Medical Care

You always have the right to choose your provider. We are not responsible for the quality of your medical care. Your providers act as independent contractors. We cannot be held liable for any injuries you get while receiving medical services or supplies.

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

Physical Examinations and Autopsy

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

Compliance with Federal & State Mandates

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

Governing Law

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

Where any Legal Action Must be Filed

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

Legal Action

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

Evaluation of New Technology

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

Replacing Another Plan

In the event the policy replaces another group contract or policy within 60 days of its termination, we will immediately cover all employees and dependents covered by the previous plan at the date of discontinuance, provided they meet the definition of a subscriber and eligible dependent under the policy and otherwise would be eligible for coverage by the previous plan.

The following applies:

- a. If you are hospitalized on the date this Plan becomes effective, we will reduce this Plan's benefits by an amount paid or payable by your prior plan. This applies until you are discharged from the hospital or the hospital benefits are exhausted, whichever comes first
- b. We will credit any deductible amounts you satisfied under your prior plan toward this Plan's deductibles
- c. You will give us information we need about the terms of your prior plan and any claim payments your prior plan made

Notices

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

13.3 ERISA DUTIES

Subscribers are entitled to certain rights and protections if this Plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA). Ask the Group if this section applies to your Plan.

Plan Administrator as Defined Under ERISA

Moda Health is not the plan administrator or the named fiduciary of this Plan, as defined under ERISA. Contact the Group for more information.

Information About the Plan and Benefits

Subscribers may examine all documents governing this Plan. This includes insurance contracts, collective bargaining agreements, updated summary plan description, and the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor (if any). This information can be obtained by written request. You will not be charged, except the Group may charge a reasonable amount for the copies. Subscribers are entitled to receive a summary of the Plan's annual financial report, if any is required by ERISA.

Continuation of Group Health Plan Coverage

Subscribers are entitled to continue healthcare coverage for themselves or their dependents if they lose coverage under this Plan because of a qualifying event. You may have to pay for such coverage. Review this handbook and the documents governing the Plan for information about the rules governing your continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for members, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate the Plan, called fiduciaries of the Plan, have a duty to do so prudently and in the interest of members. No one, including the

employer or any other person, may fire or discriminate against a subscriber in any way to prevent them from obtaining a benefit or exercising rights under ERISA.

Enforcement of Rights

If a claim for benefits is denied or no action is taken, in whole or in part, you have a right to receive an explanation, to obtain without charge copies of documents relating to the decision, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce these rights. For instance, if you ask the Group for a copy of plan documents or the latest annual report and do not receive it within 30 days, you may file suit in federal court. The court may require the Group to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Group. If a claim for benefits is denied or no action is taken, you may file suit in state or federal court after you have exhausted this Plan's appeal process (see section 9.2). In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court.

If plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or may file suit in federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, (e.g., if it finds the claim is frivolous).

Assistance with Questions

For questions about this section or your rights under ERISA, or for help obtaining documents from the Group, contact one of the following:

Employee Benefits Security Administration
Seattle District Office, 300 Fifth Ave., Ste. 1110, Seattle, WA, 98104
Phone 206-757-6781
Information and assistance is also available through their website: dol.gov/agencies/ebsa

Office of Outreach, Education and Assistance, U.S. Department of Labor
200 Constitution Ave. NW, DC, 20210
Phone 866-444-3272

You may call them to obtain publications about your rights and responsibilities under ERISA.

SECTION 14. NOTICE OF YOUR RIGHTS UNDER NO SURPRISES ACT

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

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

What is “balance billing” (sometimes called “surprise billing”)?

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

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

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

You are protected from balance billing for:

Emergency services

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

Certain services at an in-network hospital or ambulatory surgical center

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

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

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

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

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
 - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
 - Cover emergency services by out-of-network providers.
 - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
 - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

For help with surprise billing or more information about surprise medical bills, please contact us at 844-248-7877.

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

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

Nondiscrimination notice

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

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

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

If you need any of the above, call:
844-931-1775 (TDD/TTY 711)

If you think we did not offer these services or discriminated, you can file a written complaint.

Please mail or fax it to:

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

Scott White coordinates our nondiscrimination work:

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

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

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

U.S. Department of Health
and Human Services
200 Independence Ave. SW, Room 509F
HHH Building, Washington, DC 20201
800-368-1019, 800-537-7697 (TDD)

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



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

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

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

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

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

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

注: 日本語を話される場合、無料の言語支援サービスをご利用いただけます。アクセシブル(誰もが利用できるよう配慮された)な形式で情報やサービス
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(TTY: 711) までお電話ください。または、ご利用の事業者にご相談ください。

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

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

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

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

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

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

ເຂົ້າໃຈ: ຖ້າທ່ານເວົ້າພາສາ ຝຣັ່ງ, ຈະມີບໍລິການຊ່ວຍເຫຼືອພາສາແບບບໍ່ເສຍຄ່າໃຫ້ທ່ານ. ມີເຄື່ອງຊ່ວຍ ແລະ ການບໍລິການແບບບໍ່ເສຍຄ່າທີ່ເໝາະສົມເພື່ອໃຫ້ຂໍ້ມູນໃນຮູບ

แบบที่สามาดຂ້າງໄດ້. ໂທຫາເບີ 1-877-605-3229 (TTY: 711) ຫຼື ລົມກັບຜູ້ໃຫ້ບໍລິການຂອງທ່ານ.

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

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

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

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

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

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

ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन

और सेवाएँ भी निःशुल्क उपलब्ध हैं। 1-877-605-3229 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।

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

تنبیه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتكسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 1-877-605-3229 (TTY: 711) أو تحدث إلى مقدم الخدمة.

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

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

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



For help, call us directly at 844-248-7877
(En español: 888-756-7461)

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